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In the

# Supreme Court of the United States

OCTOBER TERM, 1997

LAURA MELENDEZ,

*Petitioner,*

vs.

METROPOLITAN LIFE INSURANCE CO.,

*Respondent.*

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

## PETITION FOR A WRIT OF CERTIORARI

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## QUESTION PRESENTED

What standard of review should the Courts apply to ERISA benefit determinations by plan administrators acting under a direct conflict of interest? The Circuits are split three ways over this issue.

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Petitioner Laura Melendez respectfully requests that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit.

## OPINIONS BELOW

The Opinion of the Court of Appeals is reported electronically at Semmler v. Metropolitan Life Insurance Co., 1998 WL 4069 (2d Cir. 1998) and reprinted in the Appendix ("Pet. App.") at A-1. The Opinions of the District Court are reported at 172 F.R.D. 1124 (S.D.N.Y. 1997) and 1995 WL 559390 (S.D.N.Y.) and reprinted at Pet. App. B-1 and C-1 respectively.

## JURISDICTION

The judgment of the Court of Appeals was entered on January 7, 1998. This Court's jurisdiction is invoked pursuant to 28 U.S.C. Sec.1254(l). The Federal Court of first instance in this case was the United States District Court for the Southern District of New York. The basis for federal jurisdiction in the District Court was 29 U.S.C. Sec. 1132 and 29 U.S.C. Sec.1331.

## STATUTE INVOLVED

The text of the section of the ERISA statute involved in this case, codified at 29 U.S.C. Sec. 1132(a)(1)(B), is as follows:

> [a] civil action may be brought –
>
> (1) by a participant or beneficiary --
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his

> rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan....

ERISA is comprehensive statutory scheme governing the administration of employee benefit plans. 29 U.S.C. Secs. 1001 et seq. The section at issue here authorizes beneficiaries to bring lawsuits to recover denied benefits.

## STATEMENT OF THE CASE

This case presents an egregious example of Federal injustice affecting millions of working Americans, due solely to the inability of the U.S. Circuit Courts of this Country to agree on the correct legal standard of review applicable to conflicted ERISA fiduciaries. Only the Supreme Court can resolve the conflict among the circuits and establish a uniform and fair standard.

### Procedural History

This is a putative nation-wide class action to recover health insurance benefits for post-operative pain treatment under respondent Metropolitan Life Insurance Company's group health care policies. This action was originally commenced in New York State Court on behalf of a class of both ERISA and non-ERISA beneficiaries. Based on the presence of the Federal ERISA claims, Metropolitan removed the case to the United States District Court for the Southern District of New York. After limited discovery, the parties were directed by the trial judge to cross-move for summary judgment. The District Court then entered judgment dismissing the ERISA claims based on the boiler-plate language in the policies granting respondent discretion to interpret terms of the plan. The trial judge held that in view of this language, respondent's denial of benefits was not

arbitrary and capricious. Petitioner Melendez was the named plaintiff representing the ERISA claimants. (C-11)

With respect to the remaining claims which were subject to de novo review, i.e. -- the state law contract claims and the ERISA claims under policies which did not grant discretion -- the District Court found a triable issue of fact. After the original District Judge voluntarily recused himself, a new District Judge granted reargument of the dismissal of the "discretionary" ERISA claims. In an opinion which superseded the original decision, the new Judge upheld the dismissal, and denied class certification.[1] The Court then remanded the non-ERISA state law claims -- primarily individual and local government policies -- to New York State Court. The District Court's decision on reargument was subsequently affirmed by the United States Court of Appeals for the Second Circuit. (C-1) The Second Circuit expressly declined to adopt the Eleventh Circuit standard of review, which shifts the burden to conflicted ERISA fiduciaries to justify their discretionary denial of ERISA benefits.

While the appeal was pending, the New York State Court certified the class of non-ERISA claimants and, applying the identical arbitrary and capricious standard as the District Court, came to the opposite conclusion and found that there was an issue of fact on the propriety of Metropolitan's discretionary denial of benefits for post-operative pain relief requiring trial.

As the result of the Second Circuit's deference to the Metropolitan Life Insurance Company, insured employees "protected" under ERISA must pay out of their

[1] Unless a ERISA claimant with a "on-discretionary" plan intervened. (B-1) None did.

own pockets for PCA and ENA pain following surgery, while non-ERISA claimants may seek reimbursement from the insurance company. In short, as applied by the Second Circuit, ERISA has become the basis for denying necessary health care benefits, rather than for enforcing them.

## Reasons for Granting Certiorari

There is an irreconcilable conflict among the Circuits over the proper standard of review to apply where an ERISA fiduciary's denial of plan benefits is tainted by a direct financial conflict of interest. As a result, an important area of the law governing actions for ERISA-protected employee benefits is in disarray. The Second Circuit applies a highly deferential standard which, petitioner submits, effectively negates a crucial portion of this Court's landmark ERISA decision in Firestone v. Bruch (see Point II infra) -- and permits conflicted fiduciaries to escape meaningful review of the factual bases for their decisions to withhold benefits. Petitioner urges this Court to grant certiorari to endorse the better reasoned position of the Eleventh Circuit, which subjects such conflicted fiduciaries to more searching review.[2] (The law of the various circuits on this issue is analyzed in Point I below.)

ERISA is the principal protection for employee benefits such as medical, disability and retirement coverage -- benefits which provide invaluable financial security for millions of working Americans and their families. When these benefits are wrongfully withheld, a beneficiary's only recourse is to bring an action under ERISA, which pre-empts all state law remedies. Since the standard of review applied by the Courts will often determine

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[2] The Fourth and Tenth Circuits apply yet a third intermediate standard.

the outcome of such actions, the issue here has a direct impact on the ability of ERISA beneficiaries to obtain their rightful benefits.

Resolution of the conflict among the circuits over the proper standard of review will advance a primary purpose of the ERISA statute -- i.e. to establish appropriate nationwide standards governing employee benefit plans in order to promote responsible plan administration and protect employees' benefits. The need to vindicate this statutory objective is especially pressing in cases such as this one, where an administrator makes a coverage determination applicable to all its beneficiaries throughout the several circuits. A uniform standard of review will eliminate the possibility that these determinations will subject class members to two or more directly conflicting standards of scrutiny, and substantially reduce the danger of inconsistent judicial decisions. These are compelling reasons for this Court to grant certiorari and set the proper standard of review in accordance with purposes underlying the ERISA statute. See S.C.R. Rule 10(a).

This case presents a prime example of an ERISA fiduciary whose financial interests are directly opposed to those of plan beneficiaries. At the time of the denial of claims at issue here, respondent was a huge health insurer which had denied coverage across-the-board for specialized pain management services to alleviate post-surgical pain -- services it contends are not "medically necessary." As the record demonstrates, respondent's practice is contrary not only to the recommendations of claimants' treating physicians, but also to the views of leading experts commissioned by a Federal agency of the Department of Health and Human Services to investigate the problem of inadequate pain treatment and to propose solutions. In view of the conflict between respondent's determination and the views of leading medical authorities,

the common sense approach would be to closely scrutinize respondent's denial of coverage, to ensure that it was medically justified, and not the product of the insurer's financial incentive to limit benefit payouts.

Petitioner respectfully submits that in reviewing denials of ERISA benefits, the Second Circuit has lost sight of the common sense view that self-serving benefit denials should be viewed with some skepticism. In the Second Circuit, such denials are, in effect, presumptively correct, and receive excessive judicial deference, unless a beneficiary can sustain the burden of coming forward with direct evidence proving that the financial self-interest affected the benefit decision. Practically speaking, this requirement places a burden on ERISA claimants which they will be incapable of meeting, since the effect of financial self-interest is rarely susceptible of direct proof. Rather, self-interest is an unstated but powerful influence, which inevitably tends to color a decision-maker's judgement and tempt decide in its own favor. For this very reason, the right to bring disputes before an impartial tribunal is central to our concept of justice. As Founding Father James Madison once observed (Federalist No. 10):

> No man is allowed to be a judge in his own cause; because his interest would certainly bias his judgment, and, not improbably, corrupt his integrity. With equal, nay with greater reason, a body of men, are unfit to be both judges and parties, at the same time;
>
> (Emphasis added.)

By dint of their financial stake in the outcome, insurers like Metropolitan are, in effect, both judges and parties in determinations of insurance benefits. Excessive judicial deference to an insurer's denial of benefits, deprives

ERISA beneficiaries of meaningful review by an unbiased tribunal -- a situation which contravenes both the basic principle of justice articulated by Madison and the overarching purpose of the ERISA statute to provide protections against self-dealing by plan administrators to working people and their families.

## The Decision Stands ERISA On Its Head

Ironically, the result of the Second Circuit approach in this case is that individuals who are supposedly protected by ERISA have been denied any recovery, while the state law claimants seeking identical benefits -- but who do not have the "advantage" of ERISA protection -- have received class certification and are proceeding to have their claims adjudicated on the merits at trial in state court. This outcome is contrary to Congress's remedial purpose in enacting ERISA, viz. to provider superior protection to beneficiaries than allowed under prior state law. By overemphasizing the deference due to ERISA administrators, while failing to give sufficient weight to an insurer's conflict of interest, the Second Circuit has unintentionally transformed ERISA "protection" into a liability. The panel's decision permits conflicted ERISA fiduciaries to promote their own interests at the expense of beneficiaries by withholding benefits, secure in the knowledge that they are largely immune from judicial accountability. This situation requires the intervention of this Court.

## Factual Background

The underlying facts of this case illustrate how ERISA beneficiaries are injured when inordinate deference is shown to conflicted fiduciaries, by making it difficult or impossible for them to afford vital medical services. The specific employee benefit claimed here is health insurance coverage for post-operative pain control,

also referred to as post-operative pain management. As its name suggests, pain control treatment is designed to alleviate the severe and physically harmful pain that invariably follows major surgery. These treatments are rendered by specialists in the pain management field, principally by anesthesiologists.

Post-operative pain is treated primarily through the modalities of "epidural narcotic administration" and "patient controlled analgesia" (commonly referred to as "ENA" and "PCA") -- the services received by the named plaintiffs and class members here.[3]

A crucial part of ENA and PCA is monitoring the patient with follow-up visits by a trained and experienced professional once or twice a day (over an average of 3 days) to observe the patient, review his or her progress, and make necessary adjustments to drugs, dosages and infusion intervals.

The recent increased attention to pain management has redressed a serious shortcoming in American medical practice, i.e., the undertreatment of pain

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[3] Epidural narcotic administration is a technique whereby the physician places a catheter in the epidural space which surrounds the patient s spinal column and the narcotic is injected through the catheter which remains in place as long as necessary.

PCA is a technique which has come into widespread use over the last few years. PCA is particularly suitable for reducing post-operative pain and extreme pain from chronic conditions such as cancer. In PCA, the physician (or a nurse under physician supervision) programs a metered intravenous infusion pump to deliver a measured dose of narcotic or other analgesic drug to build a constant but safe level of painkiller in the patient's bloodstream and prevent or mute the onset of pain. The medication is delivered automatically in continuous intervals or on demand, by the patient pressing a button on the pump programmed in advance to provide the proper dosage and prevent overdosing.

after surgery. This deficiency was expressly recognized by the Agency for Health Care Policy and Research, an arm of the United States Department of Health and Human Services, established to "enhance the quality, appropriateness and effectiveness of health services and access to these services." Beginning in 1990, the AHCPR convened a multidisciplinary panel of experts to study the field of post-operative pain control and issue a Clinical Practice Guideline to assist practitioners in patient treatment. This U.S. Government publication, entitled Acute Pain Management: Operative or Medical Procedures and Trauma ("Guideline"), found that historically over half of surgical patients have been forced to suffer unrelieved post-operative pain. This undertreatment was largely due to the outdated and erroneous belief that post-operative pain, although uncomfortable, is harmless and inevitable. In fact, the Guideline noted, such pain is destructive, and actually retards recovery and tended to increases the duration of hospital stays. PCA and ENA are recognized in the Guideline as procedures which have helped rectify the problem of undertreated post-operative pain. See Guideline, pp. 15, 20.

Defendant's Decision To Deny Pain Benefits In All Cases

Defendant's standard policies require it to cover physician services which are "medically necessary in terms of generally accepted medical standards." In determining whether claims meet this standard, defendant, as an ERISA fiduciary, must act "solely in the interests of beneficiaries'" and "with the care, skill, prudence and diligence' of the traditional prudent man.'" Donovan v. Bierwirth, 680 F.2d 263, 270 (2d Cir.), cert. denied, 459 U.S. 1069, 103 S. Ct. 488 (1982) Plaintiffs submit that under any fair reading of the record, it is plain that defendant made its decision to deny pain management claims in a cavalier fashion in violation of its duties under ERISA. Defendant's decision was made by a Committee staffed exclusively by

salaried company personnel. These individuals were concededly unqualified in anesthesia, uninformed about current pain management techniques, and unfamiliar with the nature of PCA and ENA. The Committee admittedly failed to consult the medical literature on the subject or undertake any other research into the benefits of PCA or ENA administration by anesthesiologists. The sole external "input" was a one sentence oral report from a now deceased committee member who supposedly consulted outside experts but flatly refused to identify them or to reveal their qualifications. In sum, the record leaves little doubt that respondent's primary rationale for denying coverage was the outlook expressly rejected by the Guideline, i.e, that post-operative pain control is an undemanding adjunct to surgery, requiring no special expertise, and can be adequately handled by the surgeon writing orders to floor nurses for intra-muscular injections.

In any other context, a medical judgment which is unsupported by any medical evidence (other than post hoc litigation evidence by paid medical "experts"-- none of whom are pain-management specialists) or by any factual investigation, but which happens to save the insurance company millions of dollars at the expense of its insureds, would be regarded as the obvious product of the insurer's self-interest. However, under ERISA, such a judgement is presumptively deemed "reasonable." This state of affairs directly contravenes ERISA's purpose.

## POINT I

## THE SECOND CIRCUIT DECISION CONFLICTS WITH AT LEAST TWO OTHER CIRCUITS

The conflict among the Circuits at issue here arises out of their inconsistent interpretations of this Court's decision in Firestone Tire & Rubber v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 957 (1989). Firestone held that where a "benefit plan gives the administrator or fiduciary discretionary authority to determine benefits or to construe the terms of the plan," denials of benefits are to be reviewed under an "arbitrary and capricious" standard of review. Id. Firestone, however, tempered this rule by also holding that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion.'" (Id., quoting Restatement (Second) of Trusts, Sec. 187, cmt.d (1959). (Emphasis added.) Subsequently, as the Circuits were called upon to apply Firestone, disagreement arose over how precisely to "weigh" the presence of a conflict. The approaches of several of the Circuits to this question are now directly contradictory.

### A. The Eleventh Circuit "Shifting the Burden" Approach

Petitioner here unsuccessfully urged the Second Circuit to adopt the holding of the Eleventh Circuit Court of Appeals in Brown v. Blue Cross & Blue Shield, 898 F.2d 1556 (11th Cir. 1990), cert. denied, 498 U.S. 1040, 111 S.Ct. 712 (1991), a case involving a denial of medical insurance coverage by an insurer paying benefits out of its own pocket. In considering the proper standard of review to apply, the Brown Court pointed out the obvious distinction between insurance companies and conventional, non-conflicted fiduciaries:

> Because an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business. That is, when an insurance company serves as ERISA fiduciary to a plan composed solely of a policy or contract issued by that company, it is exercising discretion over a situation for which it incurs "direct, immediate expense as a result of benefit determinations favorable to [p]lan participants." (Citations omitted.) (898 F.2d at 1562) (Emphasis added.)

The insurer's self-interest provided a constant temptation "to favor, consciously or unconsciously, its interests over the interests of plan beneficiaries." Id. at 1565 (citation omitted.) (Citing widely-accepted trust law doctrine.)

> The Court thus determined that:
> [t]he inherent conflict between the fiduciary role and the profit making objective of an insurance company makes a highly deferential standard of review inappropriate. 896 F.2d at 1562. (Emphasis added.)

The Brown Court, however, believed that Firestone prohibited it from dispensing with the "arbitrary and capricious" standard and imposing straight de novo review. Nonetheless, the Court determined that, under common law trust principles applicable to ERISA, the arbitrariness standard must be "shaped by the circumstances of the inherent conflict of interest." Id.

Brown therefore devised the following arbitrariness test which required the conflicted insurer to justify its denial of benefits:

> when a plan beneficiary demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits determinations, the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest. That is, a wrong but apparently reasonable interpretation 12 is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries. 898 F.2d at 1566-67.[4]
> (Emphasis added.)

This formula has the virtue of (1) being directly supported by well-established trust law principles which are an integral part of ERISA; (2) complying with this Court's Firestone opinion, and (3) avoiding an interpretation of ERISA that "'would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.'" Id. at 1563 quoting Firestone 109 S.Ct. at 956. Regrettably, the Second Circuit has declined to adopt this standard.

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[4] The Brown decision made it clear that:

> the fiduciary's interpretation first must be "wrong" from the perspective of de novo review before a reviewing court is concerned with the self-interest of the fiduciary.
>
> 898 at 1567, n. 12. (Citations omitted.)

B. The Second Circuit Approach: Patient Must "Prove the Effect of the Conflict"

The Second Circuit has repeatedly rejected the Brown approach, as it reconfirmed in this very case:

> [Petitioner] Melendez asks us to adopt the reasoning of Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1563 (11th Cir. 1990), which shifted the burden to the fiduciary to prove that its interpretation of the plan was not colored by its conflict of interest. However, we have specifically declined to follow Brown three times in as many years. See Whitney v. Empire Blue Cross & Blue Shield, 106 F.3d 475 (2d Cir. 1997), Sullivan, 82 F.3d 1251; Pagan v. NYNEX Pension Plan, 52 F.3d 438 (2d Cir. 1995).

Semmler v. Metropolitan Life, 1998 W.L. 4069 *1 (2d Cir.) (C-4)

Rather than follow Brown, the Second Circuit stressed that it is plaintiff's burden to prove that a conflict of interest influenced the decision to deny benefits. This approach was most clearly articulated in the Second Circuit Opinion in Sullivan v. L.T.V. Aerospace, supra, where the Court expressly "decline[d] to concur with the rule in Brown..." (82 F.3d at 1255) and instead held:[5]

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[5] Sullivan articulated a two-step inquiry in cases applying the arbitrary and capricious standard to a conflicted fiduciary:

> First, whether the determination made by the administrator is reasonable, in light of possible competing interpretations of the plan; second, whether the evidence shows that the administrator (footnote continued)

a reasonable interpretation of the Plan will stand unless the participants can show not only that a potential conflict of interest exists, ... but that the 'conflict affected the reasonableness of the Committee's decision.' Id. at 1259 (quoting Pagan v. NYNEX Pension Plan, 52 F.3d 438, 443 (2d Cir. 1995)). (Emphasis added.)

In direct conflict with the Eleventh Circuit rule that the conflicted fiduciary bears the burden to justify its decision, the Second Circuit unequivocally holds that "the burden of proving that the conflict of interest affected the administrator's decision rests with the plaintiffs." 82 F.3d at 1259 (Emphasis added.)[6] As argued in Point II below, petitioner submits that the Brown approach is both fairer to beneficiaries and more consistent with Firestone and should be adopted by this Court.[7]

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was in fact influenced by such conflict. If the court finds that the administrator was in fact influenced by the conflict of interest, the deference otherwise accorded the administrator's decision drops away and the court interprets the plan de novo.

[6] In the event plaintiff carries this burden, the tainted decision is not invalidated. Rather, the "deference otherwise accorded the decision" merely "rops away, and the court interprets the plan de novo." 82 F.3d " 1256. This aspect of Sullivan also directly conflicts with Brown, where, as noted above, the first step is to determine that a fiduciary's interpretation was "wrong from a de novo perspective" before requiring it to show that its action "was not tainted by self interest." 898 F.2d at 1366, n.12.

[7] The Second Circuit in Whitney v. Empire Blue Cross Blue Shield, supra, confirmed that Sullivan, not Brown, was applicable to denials of health insurance coverage by insurers paying benefits out of their own assets.

The Ninth Circuit Approach

The Ninth Circuit has adopted an approach that, in practical terms, imposes a similar evidentiary burden on plaintiffs as that imposed by the Second Circuit in Sullivan. See Lang v. Long Term Disability Plan of Sponsor-Applied Remote Technology, 1997 W.L. 561555 (9th Cir.) holding that review of an apparently conflicted fiduciary's benefit denial is for abuse of discretion, unless the beneficiary:

> come[s] forward "with material, probative evidence, beyond the mere fact of the apparent conflict, tending to show that the fiduciary's self interest caused a breach of the administrator's fiduciary obligations to the beneficiary."[8]

Id. at *3 (citations omitted.) See also Snow v. Standard Ins. Co., 87 F. 3d 327, 329 (9th Cir. 1996)

The Ninth Circuit's approach, therefore, is also in direct tension with Brown.

The Fourth and Tenth Circuit's "Sliding Scale"

The Fourth Circuit follows yet a third standard when reviewing discretionary decisions of ERISA fiduciaries. This approach is illustrated by the decision in Bedrick v. Travelers Ins. Co., 93 F.3d 149 (4th Cir. 1996). Bedrick involved an insurer's exercise of discretion to interpret the term "medical necessity" in a major medical

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[8] Unlike Sullivan, however, under Lang, in the Ninth Circuit, if the plaintiff carries its burden, review simply becomes "less deferential," not de novo. Lang, 1997 W.L. 56155 at *3.

plan. The insurer exercised that discretion to deny medical coverage for physical therapy to a handicapped child. Bedrick declined to either follow the Brown or Sullivan burden of proof analyses. Rather, the Fourth Circuit determined that the conflicted administrator was necessarily entitled to "some deference," but that deference "would be lessened to a degree necessary to neutralize any untoward influence resulting from the conflict." Id. at 152. (Citations omitted.)

The Tenth Circuit adopted a similar approach in a recent case addressing "exactly how...a conflict of interest effects the Court's standard of review." Chambers v. Family Health Plan Corp., 100 F.3d 818, 825 (10th Cir. 1996). The Chambers Court espoused a "sliding scale" approach, pursuant to which the Court applies the arbitrary and capricious standard, but diminishes the deference shown to the administrator, in proportion to the seriousness of the conflict.[9]

As the above survey of the Circuits makes plain, there are at least three standards being applied to decisions of conflicted fiduciaries, and the Circuits are unwilling to come to a consensus on the critical issue. It is imperative, therefore, that this Court intervene and adopt a uniform standard for the nation. This case, in which the conflict was explicitly acknowledged by the Circuit Court, presents a perfect opportunity to do so.

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[9] The Chambers Court emphasized the conflict among the Circuits stating "all the Circuit Courts agree that a conflict of interest triggers a less deferential standard of review. The Courts, however, differ over how this lesser degree of deference alters the review process." (100 F.3d at 825 n. 1) See 100 F.3d at 826 quoting inter alia, on Fourth Circuit Standard in Doe v. Group Hospitalization and Medical Services, 3 F.3d 80, 86 (4th Cir. 1993).

## POINT II

## THIS COURT SHOULD GRANT CERTIORARI IN ORDER TO ADOPT THE BETTER REASONED ELEVENTH CIRCUIT RULE

Certiorari is warranted here, not simply to resolve the conflict among the Circuits, but to resolve it in a way that furthers the primary purpose of ERISA -- i.e. to protect employee benefit rights.

The Second Circuit approach is contrary to ERISA's primary purpose, because it places an evidentiary burden on plaintiffs which they will rarely, if ever, be able to meet. The simple fact, long known to the law of trusts, is that conflicts, while pernicious, usually leave no overt trace. For this reason at common law all self-interested transactions were voidable by the beneficiary, whether or not he or she could show actual harm. This has been the rule since the days of Chancellor Kent, who in speaking about the purchase of trust property by a trustee, observed:

> However innocent the purchase may be in the given case, it is poisonous in its consequences. The cestui que trust is not bound to prove, nor is the Court bound to judge, that the trustee has made a bargain advantageous to himself. The fact may be so, and yet the party not have it in his power, distinctly and clearly, to show it. There may be fraud, as Lord Hardwicke observed, and the party may not be able to prove it. It is to guard against this uncertainty and hazard of abuse, and to remove the trustee from temptation, that the rule does and will permit the cestui que trust to come, at his own option, and without showing actual injury, and

> insist upon having the experiment of another sale.
>
> Davoue v. Fanning, 2 Johns.Ch. 252, 261

This remains the general rule to this day, as a leading treatise on the subject confirms:

> For the sake of protecting [beneficiaries] against this risk equity forbids the disloyal transaction and does not consider its actual merits or effects which in many cases may be concealed.
>
> Bogert, Trust and Trustees, (6th Ed. 1987) at 342.

Subsequent to Sullivan, a panel of the Second Circuit itself acknowledged the practical impossibility of proving the effect of a conflict, for the sensible reason that: "One would not expect to find decision-makers saying, 'in view of our conflict, we find the Plan's construction [in favor of denying benefits] to be reasonable.'" DeFelice v. American Ins. Co., 112 F.2d 59, 66 (2d Cir 1997). Administrators are far more likely to categorically deny that self-interest affected their decision -- exactly as happened in this case. Here, the District Court actually accepted the denials of wrong doing at face value, and accorded them full weight in finding the insurance company's decision to be "reasonable." Petitioner submits that such an attitude is unrealistic and naive, as well as inconsistent with ERISA's purposes.

The DeFelice Court also pointed out that the Second Circuit approach effectively negates Firestone's ruling as to the impact of a conflict of interest. 112 F.2d at 66. By imposing the requirement that plaintiffs prove what is unprovable, the Second Circuit essentially removes the

conflict of interest as a factor in evaluating the benefit denial. Hence the observation in DeFelice that:

> Pagan has essentially held that if the administrative interpretation is reasonable, then the conflict is of little, if any, consequence. Yet Firestone instructs that a conflict is a "factor" in determining whether there has been an abuse of discretion. Sullivan, likewise, repeats Pagan and again fails to give weight to the conflict because the plaintiff failed expressly to explain how the conflict affected the reasonableness of the interpretation.
>
> (112 F.2d at 66, n. 3)

In view of the inconsistency between the Second Circuit approach and the earlier precedent of this Court, the DeFelice panel openly declared its preference for "the reasoning of Brown v. Blue Cross and Blue Shield of Alabama, Inc., 898 F.2d 1556 (11th Cir. 1990) (when ERISA plan beneficiary demonstrates a substantial conflict of interest on the fiduciary's part, the burden shifts to the fiduciary to prove that its interpretation of the plan was not tainted by self interest)." (DeFelice, 112 F.3d at 66.) However, the panel was constrained by Sullivan, et al. to adhere to the established Second Circuit rule. The Second Circuit is therefore itself sharply divided over the proper standard of review. It is time for this Court to grant certiorari to heal the division within and among the Circuits on this issue, by formally adopting the reasoning in Brown.[10]

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[10] The Brown approach is also preferable to the Fourth and Tenth Circuit sliding scale approaches, which provide no guidance on how far to slide the scale in any given case and are thus, in essence, totally subjective.

## CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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# APPENDIX A

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------X

ANTON SEMMLER, ROSEMARIE LUNNY, MARIO GAITI, DONNA POOLE, and LAURA MELENDEZ, individually and on behalf of all others similarly situated,

Plaintiffs,

- against -

METROPOLITAN LIFE INSURANCE,

Defendant.

MEMORANDM AND ORDER
94 Civ. 5549 (WK)

----------x

WHITMAN KNAPP, SENIOR D.J.

Both plaintiffs and defendant cross-move for summary judgment in this action to obtain medical insurance coverage under a number of policies for what they refer to as "post-operative pain management services." The amended complaint states causes of action for breach of contract and for violation of Section 502 of ERISA, 29 U.S.C. Sec 1132(a)(1)(B) and (g)(1). For reasons which follow, we grant defendant's motion only as to plaintiff Laura Melendez and deny plaintiffs' motion.

## BACKGROUND

The plaintiffs are Anton Semmler, a beneficiary of defendant's Empire medical insurance plan who under-went two surgeries for colitis in August 1992 and January 1993; Mario Gaiti, also a beneficiary of defendant's Empire'splan,who in July 1993 had a cancerous kidney removed; Rosemarie Lunny, another beneficiary of defendant's Empire plan who in January 1994 underwent extensive abdominal surgery; Donna Poole, a beneficiary of an ERISA-governed major medical plan provided by her husband's employer, Orange & Rockland Utilities Inc., who in February 1992 underwent surgery to have excess skin removed after she lost a great deal of weight; and Laura Melendez, a beneficiary of the Securities Indemnity Automation Corporation Plan, an ERISA-governed plan for which defendant provides major medical insurance, who in November 1993 underwent emergency surgery to remove an inflamed ovary.

All plaintiffs except Gaiti were treated for their post-operative pain with patient-controlled analgesia (hereinafter "PCA"). Plaintiffs describe PCA in the following manner:

> the physician pre-programs a device known as a metered intravenous infusion pump to administer a measured dose of analgesia [cite omitted]. The patient receives the dose by pressing a button on the pump to "self medicate" as needed, and maintain a constant level of pain killer in the blood stream to mute or prevent the onset of pain. The pump is specifically programmed to prevent overdosing and the physician monitors the

> patient daily in order to check on the effectiveness of the medication, dosage amounts and frequency of administration.

Pl. Mem. In Support of Summary Judgment Motion at 12.

Gaiti, on the other hand, received epidural narcotic administration (hereinafter "ENA") treatment for his pain. Plaintiffs describe ENA as follows:

> a pain management technique wherein an anesthesiologist inserts a catheter into the epidural space surrounding the patient's spinal column. The catheter is used to administer pain killing narcotics which are injected intermittently or infused continuously. [cite omitted]. * * * Although used for post-operative pain management, the catheter is often inserted pre-operatively. * * * As with PCA, the administration of [ENA] requires vigilant monitoring of the patient. The physician visits the patient at least once a day to assess the effectiveness of the medication chosen and the adequacy of the dosage amounts and intervals.

Id. at 14.

Defendant, plaintiffs' medical insurance provider, paid 80% of what it refers to as the Asurgical anesthesia fee" incurred by plaintiffs Semmler, Gaiti and Lunny on the day of their surgery and the entire amount for plaintiffs Poole and Melendez for such services on such day. However, defendant has refused to pay additional bills which plaintiffs received from their respective

anesthesiologists. With the exception of Semmler and Gaiti, each plaintiff was additionally billed for a consultation with his anesthesiologist on the day of his surgery and for a number of follow-up visits by his anesthesiologist on following days. Semmler received from his anesthesiologists bills for two consultations, each of which was performed on the day of each of his surgeries, and for numerous visits on the days following each surgery. Gaiti's anesthesiologist billed him for the insertion of an epidural catheter for post-operative ENA on the day of his surgery and for follow-up visits on succeeding days.

Plaintiffs Semmler, Lunny and Gaiti are covered under defendant's Empire Plan, which limits coverage in the following manner.

COVERED MAJOR MEDICAL EXPENSES

> Covered medical expenses are defined as the reasonable and customary charges for covered medical services performed or supplies prescribed by a Doctor, except as otherwise provided, due to your sickness, injury or pregnancy. These services and supplies must be Medically Necessary in terms of generally accepted standards as determined by Metropolitan. No more than the Reasonable and Customary Charge for medical services and supplies will be covered by this plan.

Empire Plan, Pl. Ex. 10 at 39-40; 42. The Empire Plan also contains the following provisions (at 39):

B. In-Hospital Doctor's Visits

You are covered for Doctor's visits while an in-patient in the Hospital if such visits are not related to a surgery. Benefits for visits related to a surgery are included in the scheduled amount for the surgery.

C. Surgery

You are covered for the services of a Doctor for surgery, including post-operative care, whether performed in or out of a Hospital.

D. In-Hospital Anesthesia

You are covered for anesthesia services if such services are performed in connection with in-hospital surgery, maternity care or shock therapy.

The Plan further provides (at 50):

The fact that a Doctor may recommend that a covered person receive a surgical or medical service or be confined to a hospital does not mean:

(1) that such service or confinement shall be deemed to be Medically Necessary; or

(2) that benefits under this plan will be paid for the expense of such service or confinement.

The Empire Plan defines "reasonable and customary charge" as follows (at 35):

> Reasonable and Customary Charge means the lowest of:
>
> (1) the actual charge for a service or supply; or
>
> (2) the usual charge by the Doctor or other Provider for the same or similar service or supply; or
>
> (3) the usual charge of other Doctors or other Providers of similar training or experience in the same or similar geographic area for the same or similar service or supply.

The plans covering plaintiffs Poole and Melendez contain a similar provision to that in the Empire Plan regarding "Covered Major Medical Expenses." Poole's plan includes the following relevant provisions:

> D. In-Hospital Doctors' Visits
>
> Charges for the professional visits by a Doctor to a Covered Person if:
>
> (1) the visits are made while the Covered Person is confined as an inpatient in a Hospital; and

(2) that Hospital confinement is for a sickness or injury;

except that charges for the following will not be considered as In-Hospital Doctors' Visits:

(a) charges for visits made on and after the day a surgical operation is performed if (i) surgical benefits are provided for that procedure and (ii) the visit is made by a Doctor who performed or assisted in the operation;...

M. Anesthetics and their administration.

Def. Reply Ex. 4 at 36-37. Melendez's plan provides:

3. Medial Services or Supplies which may be Covered Medical Expenses

Type A Expenses

Emergency care in a Hospital * * *

Type B Expenses

The following services except when provided under Type A expenses:
(1) Room and board in a Hospital * * *

(5) other Hospital services required for medical and surgical treatment.

(11) Anesthetics and their administration.

> 4. Exclusions -- Medical Services or Supplies which are NOT Covered Medical Expenses...
>
> (12) Services or supplies to the extent that benefits are otherwise provided under This plan or under any other plan which the Employer (or an affiliate) contributes to or sponsors.

Def. Ex. 2, at 13-15.

Plaintiffs move for summary judgment, arguing that defendant must pay the additional anesthesiologists bills under the terms of their health plans and, with regard to Poole and Melendez, pursuant to ERISA. Defendant contends that it has no such obligation under the plans, and that its decision to deny the claims of Poole an Melendez were neither arbitrary nor capricious and must, therefore, be upheld under ERISA.

Defendant also moves for summary judgment against all plaintiffs on the basis that they have failed to join their surgeons in this action. It argues that the surgeons are Anecessary parties" to this action under F.R.Civ.P. 19(a).

Defendant raises additional arguments in favor of summary judgment against plaintiffs Poole and Melendez on ERISA-related grounds. First, defendant claims that it is not liable to plaintiff Poole because under an ERISA-governed plan only the ERISA-defined fiduciary of the plan can be sued for adverse benefits decisions, and that the fiduciary of Poole's plan is her husband's employer,

Orange and Rockland Utilities, Inc. Second, defendant contends that neither Poole nor Melendez have exhausted her administrative remedies, as she must do before filing any action under ERISA.

Plaintiffs' Motion and Supporting Declarations and Exhibits

The basis of plaintiffs' motion fur summary judgment is that the PCA and ENA services provided plaintiffs by their anesthesiologists were "medically necessary" and are therefore covered by the plans; and that defendant has failed to show that it is being asked to pay more than the "reasonable and customary charge" for the such services.

Plaintiffs contend that both PCA and ENA are aggressive, constantly improving forms of post-operative pain treatment which are now considered to be medically necessary by the medical profession even where no complications relating to the surgery arise. In support of this claim plaintiffs cite numerous texts from the medical field. See e.g. Ferrante (ed.) Patient Controlled Analgesia at 195 (1990); U.S. Dep't of Health and Human Services, Acute Pain Management: Operative or Medical Procedures and Trauma (Feb. 1992). Plaintiffs have also cited an article submitted by defendant entitled, "Development of an Anesthesiology-based Postoperative Pain Management Service." Decl. of Robert J. Fuller, Ex. 9. The article states (at 100):

> Despite advances in knowledge or pathophysiology, pharmacology of analgesics, and the development of more

> effective techniques for post operative pain control, many patients continue to experience appreciable discomfort. Just as chronic pain management has become a special area of medical practice, treatment of acute pain deserves similar commitment by practitioners with special expertise.

Plaintiffs further argue that PCA and ENA "employ sophisticated technology, require close physician supervision, and are performed by physicians with special expertise in pain management." Pl. Mem. in Support of Motion for Summary Judgment at 2. Whereas "post-operative pain treatment in the past was largely confined to written orders from the surgeon to nursing staff for analgesia injections as needed'...," id. at 25, plaintiffs contend, PCA and ENA require a physician to perform the following functions:

> 1. to examine and evaluate the patient;
>
> 2. to meet with the patient to discuss the various pain management options;
>
> 3. to prescribe and institute the appropriate pain management technique.
>
> 4. to select the proper medication dosage intervals and dosage amounts; and
>
> 5. to monitor the patient with follow-up visits usually once a day for several days.

Id. at 16-17. According to plaintiffs, nurses may administer PCA and ENA, but only "under the supervision and at the

direction of the pain management physician." Pl. Reply Mem. at 21. Thus, plaintiffs argue, PCA an ENA are so labor intensive that they simply cannot be covered by the fee package which defendant pays to the surgeon. According to plaintiffs, that package covers only the simpler, more established practice of providing patients with intramuscular injections.

Plaintiffs equally insist that neither PCA nor ENA services are included in the fees defendant pays to the anesthesiologist for "surgical anesthesia" -- anesthesia administered on the day surgery takes place. Those fees, according to plaintiffs, cover only one post-operative visit to the patient. The surgical anesthesiologist is not responsible for any further follow up, plaintiffs argue, and where he or she is asked to provide such follow up he or she would be performing additional services.

In support of these contentions plaintiffs have submitted declarations from three anesthesiologists, Chandra Sivakumaran, M.D., Director of the Department of Anesthesiology at the Good Samaritan Hospital in Suffern, New York; Louise E. Fierro, M.D., Chief of the Department of Anesthesiology at Lenox Hill Hospital in New York, New York; and Steven M. Shoun, [sic] M.D., Director of the Department of Anesthesiology at South Nassau Communities Hospital in Oceanside, New York. The declarations corroborate plaintiffs' theory that PCA and ENA can be administered only with the assistance of anesthesiologists (or others with similar expertise in pain management), require significant supervision and follow-up visits by a physician, and are not compensated for in the global package received by the operating surgeon.

In her declaration, Sivakumaran states that at Good Samaritan Hospital, only anesthesiologists can prescribe PCA services "and monitor the daily effectiveness of the PCA pain management." Sivakumaran Decl. at 1. Moreover, she contends, "[t]he institution and administration of PCA is the anesthesiologist's responsibility, even if the nurse physically sets up the PCA pump, and the anesthesiologist's direct supervision is required." Id. at 2 (emphasis in original). With regard to ENA, Sivakumaran further states that:

> most surgeons are not qualified to deal with complications arising from insertion of epidural catheters, and therefore hospitals, including Good Samaritan, do not grant surgeons hospital privileges to do so. This responsibility is restricted to anesthesiologists.

Id. at 4.

Declarant Fierro asserts that PCA and ENA are "much more technically sophisticated than simple injections, and must be initiated and supervised by physicians with pain control expertise -- the vast majority of whom are anesthesiologists." Fierro Decl. at 3. Declarant Shoum provided PCA treatment to plaintiff Semmler in January 1993. In his declaration, he states that:

> The administration of PCA and [ENA] are not only more effective than intermuscular injections which were customarily prescribed by the surgeon and administered by the nurses. As a rule, surgeons do not have the

> training or expertise to institute pain management therapies and consultation with a pain management expert is generally required.

Shoum Decl. at 3.

Plaintiffs have also provided the court with a portion of the 1994 American Society of Anesthesiologists "Relative Value Guide," which suggest the relative value of different services provided by anesthesiologists. Section 01996 of the Relative Value Guide assigns three "value units" to "[d]aily hospital management of epidural or subarachnoid drug administration." Reply Decl. of Peter James Clines, Ex. 2. Section 01997 assigns 2 such units to "[d]aily hospital management of intravenous patient-controlled analgesia." Id.

Defendant's Motion and Supporting Declarations and Exhibits

Defendant does not dispute the medical necessity of plaintiff's post-operative pain treatment, but only whether the additional anesthesiologist bills which it has refused to pay constitute "reasonable and customary charges" as defined under plaintiffs' health plans. It is defendant's established policy to pay what it refers to as "the surgical package" to the insured's surgeon and to include in such package an allotment for the provision of post-operative pain treatment. Defendant also pays a package fee for what it refers to as "surgical anesthesia."

These latter fees are paid to an insured's surgical anesthesiologist for services immediately before and after the operation and for normal follow-up care including, defendant asserts, the insertion of a catheter prior to surgery which will be used in the administration of post-operative ENA. Defendant provides no further coverage for normal post-operative pain treatment.[1] Thus, it argues, plaintiffs' anesthesiologists have simply double-billed them for services for which defendant had already paid either through the package fees it paid their surgeons or through the package fees it paid their anesthesiologist's fees for anesthesia services on the day of surgery.

Defendant has offered a plethora of exhibits and numerous declarations in support of three contentions: (1) that PCA and ENA are simply alternative methods of treating normal post-operative pain,[2] which in most instances surgeons and nurses can administer and monitor on the days following a patient's surgery and which do not require an anesthesiologist to perform follow-up care in the days after surgery; (2) that most insurers pay for post-operative treatment through the package fee they pay to the operating surgeon; and (3) that PCA and ENA are accounted for in the surgical package.

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[1]However, where post-operative complications arise which require extraordinary pain treatment, defendant does provide additional coverage for post-operative anesthesia services. None of the plaintiffs contends that he or she suffered any such complications.

[2]See U.S. Dep't of Health and Human Services, Acute Pain Management: Operative or Medical Procedures and Trauma (Feb. 1992) at 17, Clines Decl. Ex. 11; J. Paice, "New Delivery Systems in Pain Management", 22 Nurse Clin. North Am. 715 (1987), Fuller Decl. Ex. C-3

With respect to the role nurses and surgeons play in the administration of PCA and ENA, defendant has submitted the declaration of Annette Bongiovanni, a registered nurse who works at the Critical Care Division of Georgetown University Hospital, located in the District of Columbia. Bongiovanni has been "working in hospitals for 15 years and ha[s] been an active participant in managing patients post-operative pain." Bongiovanni Decl. at 1. Her declaration asserts that PCA and ENA are simply alternatives to the traditional forms of pain treatment. Id. at 4. It also contends that nurses and surgeons typically administer PCA and ENA after the day of surgery without assistance from an anesthesiologist. Id. While Bongiovanni concedes that when "an epidural catheter was placed by an anesthesiologist, then the analgesics are usually prescribed by him/her," she asserts:

> Although an anesthesiologist may be capable of prescribing the other routes of administration, it is not his/her role since she does not follow the patient on a daily basis as does the surgeon, who is the primary physician and responsible for the overall care.

Id.

Bongiovanni explains PCA in the following manner (at 2) (emphasis in original):

> a technique developed over the last twenty-five years for controlling pain * * * in which typically a nurse programs a metered

> intravenous infusion pump to deliver measured doses of narcotic or other drug * * * Nurses are capable and frequently do: (1) program PCA machines pursuant to prescriptions and administer narcotic analgesia via PCA machines; (2) monitor patients on PCA machines and assess the adequacy of their pain medication, (3) reprogram PCA machines to adjust analgesia within the prescribed limits as needed, [and] (4) contact primary physicians (typically surgeons for post-operative patients) or anesthesiologists in the event of problems * * *

Bongiovanni asserts that nurses similarly perform many of the functions required in ENA. Id.

Bongiovanni states that "the anesthesiologist involvement with the IV administration of PCA pumps is limited to times when the nurse is unable to successfully trouble-shoot and has exhausted the resources of her nurse colleagues." Id. at 5. She further asserts that:

> Intra-venous infusions are maintained by nurses and it is the exception rather than the rule to need anesthesiologist visits subsequent to his/her routine one-time post-operative visit which encompasses more than just pain management. For IV PCA infusions it does not seem appropriate for an anesthesiologist to charge a patient for visits specific for pain management * * *

> Post-operative pain management should be discussed by the anesthesiologist on his pre-operative visit when he is doing his general patient assessment. As far as instructing the patient on the use of the PCA pump, it is the nurses who perform this task since they are available to assist the patient throughout the duration of his hospital stay.

Id.

Bongiovanni's contentions are backed up by the declaration of Joannie Kurdziel, a registered nurse at the Fort Washington Hospital in Fort Washington, Maryland, and by numerous texts submitted by defendant.[3]

Both Bongiovanni and Kurdziel assert in their declarations that PCA does not require more physician time than does the traditional form of post-operative pain treatment -- intramuscular injections -- which plaintiffs concede is covered by defendant's surgical package. See Bongiovanni Dec. at 1-2; Kurdziel Decl. at 2-3. This assertion is echoed in a finding at one hospital that the intervention of a physician was required once during every 500 hours of PCA therapy.[4]

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[3]See J. Fitzgerald, "Let Your Patient Control His Analgesia", 17 Nursing 48 (1987), Fuller Decl. Ex. C-10; L. Ready, 68 Anesthesiology 101 (1988), Fuller Decl. Ex C-9; Position Statement on the Role of the Registered Nurse (RN) in the Management of Analgesia by Catheter Techniques (Epidural, Intrathecal, Intrapleural, or Peripheral Nerve Catheters Am. Nursing Ass'n 1991), FullerDecl. Ex. C-11.

[4]R. Bennett, et al., "Patient Controlled Analgesia", Contemporary Surgery 75, 86 (1983), Fuller Decl. Ex. C-7 (concluding that "PCA therapy could be managed within the normal framework of

Defendant has also submitted the declaration of Charles D. Sherman, Jr., M.D., who practices surgery at Highland Hospital in Rochester, New York and who has been a physician for over 30 years; the declaration of Paul K. Bronston, M.D., a practicing board certified emergency medicine physician in Los Angeles and the National Chairman of the Ethics Committee of the American College of Medical Quality, which concerns itself with quality and cost-controls in the health care industry; and the declaration of David Vanderpool, M.D., a surgeon specializing in general and vascular surgery, who has been practicing medicine for over 30 years and who currently practices surgery at Baylor University Medical Center, Parkland Memorial Hospital and Mary Shield Hospital, all of which are in Dallas, Texas.

Sherman's declaration states that

> Anesthesiologists are not usually involved in the [PCA] process. Instead, the operating surgeon and his resident staff typically write the PCA prescription and the nurse sets up and monitors the PCA machine. The surgeon and his staff review the medical chart, including PCA settings and other pain data as part of his daily post-surgical rounds, payment for each is usually included in the global surgical package fee.

Sherman Decl. at 1. See also Vanderpool Decl. at 2. Similarly, in his declaration Bronston contends that

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rounds by primary physicians).

> Post-operative care is care performed in conjunction with a surgical procedure and normally includes "rounds" or daily visits of the patient by the surgeon during the post-operative period. It does not usually include complications, exacerbations, recurrences or the treatment of other illnesses a patient may concurrently have.

Vanderpool's declaration states that

> Surgeons are capable of and from time to time do assess the effectiveness of the epidurally administered analgesia in the course of making their post-operative surgical rounds. Surgeon oversight of such epidural analgesia care is included in the global surgical package fee.

Defendant has also submitted several of its own "Claims Releases" which unequivocally inform its claims processors that in normal, uncomplicated cases they should not provide reimbursement for the post-operative visits of anesthesiologists. See Decl. of Peter James Clines in Support of Motion for Summary Judgment, Ex. 6. For example, one such "Claims Release", dated December 1992 provides (at M 000126):

> II. Patient Controlled Analgesia (PCA) Post Surgery
>
> When processing such claims the hospital charges for supplies and medication are to be

> accepted as covered medical expenses. However, physicians' fees for pain management during the period of confinement should be denied because a benefit allowance for pain control is included in our surgical payment to the operating surgeon.

The declarations of Sherman and Vanderpool, both surgeons, corroborate defendant's assertion that payment for post-operative pain treatment in general, and for PCA in particular, is typically included in the package fees paid to the operating surgeon by insurers. See Sherman Decl. at 1; Vanderpool Decl. at 3. The declarations are somewhat ambiguous with regard to coverage of ENA. Thus Sherman states (at 1-2):

> Epidural catheters are typically inserted by anesthesiologists and are sometimes used to administer anesthetics or analgesia during surgery. In other instances where an epidural catheter is used, it may be inserted post-operatively, or it may be left in place after the operation. Generally, in our hospital anesthesiologists do monitor the medications used in epidural catheters. Usually, when physician oversight of the epidural analgesia care is provided by the anesthesiologist, I would think that such care would ordinarily be included in the surgical anesthesia fee and not separately reimbursed.

See also Vanderpool Decl. at 2-3. However, Vanderpool's declaration asserts that "[s]urgeon oversight of [] epidural

analgesia care is included in the global surgical package fee."

Bronston's declaration discusses the American Medical Society's "Current Procedure Terminology" (hereinafter "CPT") which designates code numbers for each procedure performed by physicians and other health care practitioners. Bronston asserts that the CPT "is accepted as authoritative by both the payor and provider communities." Bronston Decl. at 1. His declaration explains that a "Relative Value Scale (RVS) are [sic] used in conjunction with the CPT codes to assign a basic unit value to each procedure (CPT Code) based on the complexity of the medical service delivered." Id. (emphasis in original). It then contends the following (at 1-2):

> CPT codes for surgery includes the concept of a surgical "package." A surgery package consists of pre-operative evaluations and management, the actual surgery, and the normal and uncomplicated post-operative care.
>
> * * *
>
> Post-operative care is care performed in conjunction with a surgical procedure and normally includes "rounds" or daily visits of the patient by the surgeon during the post-operative period. * * *
>
> * * *
>
> Pain control after surgery is a normal part of

> post-operative care which is recognized by the provider and payor communities.
>
> * * *
>
> Physicians have an obligation to list any appropriate modifiers to their basic RVS units. When a surgeon performs the pre-operative care and surgery and another provider performs the post-operative care, the surgeon must use a modifier in his/her CPT codes, so the payor will be alerted that the surgeon did not provide all of the services in his or her particular "packaged" case.

See also, Physician's Current Procedural Terminology (American Med. Ass'n. 4th ed. 1995), Fuller Decl. Ex. E-1 at 39, 48.

In a similar vein, defendant has filed the declaration of Gary Steinberg, the Principal-In-Charge of Medical Advisors, Inc., who has had "twenty years of diverse experience in the health care industry including hospital administration and hospital planning and consulting services." Steinberg Decl. at 1. Steinberg contends (at 2) that

> The provision of post operative pain management remains in the control of the surgeon in conjunction with nursing and pharmacy. Surgeons are traditionally reimbursed for uncomplicated follow-up care, which includes post operative pain

> control. Therefore, on anything but an exception basis, Metropolitan would be paying duplicate payments for the same service if it separately reimbursed for PCA or [ENA] * * *

Defendant has submitted a copy of a 1992 directive issued by the U.S. Health Care Financing Committee, which administrates the federal Medicare program, to "All Associate Regional Administrators for Medicare." 3 Medicare Report 906 (BNA July 24, 1992). It states that "[p]ayment for physician services treated to Patient Controlled Analgesia ("PCA") is included in the global fee paid to the surgeon." Id. at 913. And, in support of its argument that the postoperative insertion of catheters, such as that performed on Gaiti, is covered by the surgical anesthesia package, defendant has cited a recent publication by Abbott Laboratories, deemed by defendant to be the leading U.S. manufacturer of pumps used in delivering post-operative pain treatment. It states that

> the preoperative or post operative insertion of an epidural catheter is generally covered under the global anesthesia allowance and, therefore, is not eligible for separate reimbursement.

PCA Reimbursement Forum, Part 2 (Abbott Laboratories 1990) at 7.

## DISCUSSION

We first address defendant's contention that this case must be dismissed under Fed. R. Civ. P. 19 for plaintiffs' failure to join their surgeons as parties to this

case. Thereafter we turn to both plaintiffs' and defendants's contract-based arguments for summary judgment. Finally, we consider defendant's ERISA-based grounds for summary judgment.

Dismissal Under F.R.Civ.P. 19

Defendant contends that plaintiffs' surgeons are indispensable parties to this action and that the action must be dismissed for plaintiffs' failure to join them as parties. Federal Rules of Civil Procedure 19(a) (West 1995) provides in pertinent part:

> A person who is subject to service of process and whose joinder will not deprive the court of jurisdiction over the subject matter of the action shall be joined as a party in the action if (1) in the person's absence complete relief cannot be accorded among those already parties * * *[5]

Under Rule 19(b), where a person meeting the requirements of 19(a)(1) cannot be made a party, "the court shall determine whether in equity and good conscience the action should proceed among the parties before it or be dismissed."

Defendant argues that it will be subject to "double liability" if plaintiffs prevail in this action because it has already paid their surgeons a package fee covering their

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[5]Rule 19(a)(2) applies "if the person claims an interest relating to the subject of the action." As far as the court is aware, none of plaintiffs' surgeons have expressed any such interest.

post-operative pain treatment. Defendant has also suggested that its liability to plaintiffs can be properly determined only if the surgeons are parties to this action. We disagree. Plaintiffs' surgeons have no claim to any payments defendant might be required to make to plaintiffs' anesthesiologists. Moreover, defendant's liability to plaintiffs is in no way based on the actions of the surgeons but is governed by its contracts with plaintiffs. We therefore decline to dismiss this action pursuant to Rule 19.

Contract-Based Arguments for Summary Judgment

Plaintiffs argue that their anesthesiologists provided them with medically necessary services not covered either in defendant's surgical package or in its surgical anesthesia package and that therefore defendant must, pursuant to the terms of plaintiffs' plans, pay the bills for such services. Defendant admits that post-operative pain treatment is medically necessary and covered by plaintiffs' plans. However, it argues that the anesthesiologists bills are not "reasonable and customary charges" for such treatment. The thrust of defendant's argument is that its surgical package covers PCA and ENA treatment but not where they are administered by anesthesiologists as services distinct from an insured's surgery. Defendant thus contends that such anesthesiologists' services are not medically necessary.

Having reviewed the exhibits and declarations submitted by counsel, we find that a question of fact exists which prevents us from granting summary judgment to either plaintiffs or defendant based on the terms of the plaintiffs' health plans; whether or not the provision

by anesthesiologists of the initial consultation for and follow-up visits related to PCA and ENA is medically necessary and therefore covered by plaintiffs' plan.[6] While the Shoum and Fierro declarations submitted support plaintiffs' view that few surgeons have the expertise to administer these new forms of pain therapy, the Sherman and Vanderpool declarations submitted by defendant suggest otherwise. The weight to be granted to such assertions is not a matter that can be determined on summary judgment.

With regard to Poole and Melendez, whose plans are governed by ERISA, we must now consider defendant's summary judgment motion on contractual grounds in light of ERISA case law concerning our standard of reviewing its actions.

> Where a benefits plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to interpret the plan's terms, courts should apply an "arbitrary and capricious" standard when reviewing decisions of plan administrators.

Seff v. Noitu Trust Fund (S.D.N.Y 1992) 781 F. Supp. 1037, 1040, citing Firestone Tire & Rubber Co. v. Bruch 1989) 489 U.S. 101, 115 and Reichelt v. Emhart Corp. (2d

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[6]As we have noted above, the Empire plan covering plaintiffs Semmler, Gaiti and Lunny provides that "[b]enefits for visits related to surgery are included in the scheduled amount for the surgery." Although this clause seems to have some bearing in this matter, defendant has not argued that the anesthesiologists visits are not covered services but only that they do not represent "reasonable and customary charges."

Cir. 1990) 921 F.2d 425, cert. denied (1991) 501 U.S. 1231. Here Melendez's plan grants defendant such discretionary authority. It provides (at 34):

> In carrying out their respective responsibilities under the plan, the plan administrator and other plan fiduciaries shall have discretionary authority to interpret the terms of the plan and to determine eligibility for and entitlement to plan benefits in accordance with the terms of the plan.

We are unable to find any such provision in Poole's plan and defendant has not cited any. Accordingly, we must consider defendant's decision to deny Melendez' claims (but not its decision to deny Poole's) under the arbitrary and capricious standard.

Defendant has provided us with ample evidence of its own historical practice of paying for post-operative pain treatment through its surgical package and that such practice is not uncommon in the medical field. As well, defendant has made a strong showing that surgeons are usually qualified to perform all services related to PCA, the type of pain treatment which Melendez received. Thus we are unable to conclude that its decision to reject Melendez' outstanding anesthesiologist's bills was arbitrary and capricious, and we accordingly grant defendant summary judgment against Melendez.

Defendant's ERISA-Based Arguments for Summary Judgment

Defendant also moves for summary judgment against Poole and Melendez based on their alleged failure to exhaust their administrative remedies prior to bringing this action, as is required under Section 503 of ERISA, 29 U.S.C. Sec 1133 (---). As we have above granted defendant summary judgment as to Melendez, we need only consider its ERISA-based arguments as to Poole.

"[E]xhaustion in the context of ERISA requires only those administrative appeals provided for in the relevant plan or policy." Kennedy v. Empire Blue Cross & Blue Shield (2d Cir. 1993) 989 F.2d 588, 594. Where, however,

> claimants make a clear and positive showing that pursuing available administrative remedies would be futile, the purposes behind the requirement of exhaustion are no longer served, and thus a court will release the claimant from the requirement.

Id.

Poole's plan provides that a plan beneficiary may request a review of denied claims by defendant within sixty days after notice of the denial. See Decl. of Robert J. Fuller, Ex. D3 at 84. Poole appealed to defendant under the above-cited provision to no avail. Without quoting a particular provision, defendant asserts that Poole's plan provides her with the right to further appeal any denial of claims to Orange and Rockland Utilities, Inc., her Plan Administrator (hereinafter "Orange and Rockland"). We

find no such provision in her plan. Accordingly, we deny defendant's motion on the ground that Poole failed to exhaust her administrative remedies.

Defendant has another basis for its summary judgment motion against Poole: it contends that it is not the ERISA-defined fiduciary of her plan and therefore not liable under ERISA. According to defendant that role is filled by her husband's employer, Orange and Rockland.

> ERISA defines a fiduciary as a party who "exercises any discretionary authority or discretionary control respecting management of [a] plan or exercises any authority or control respecting management or disposition of its assets." 29 U.S.C. Sec 1002(21)(A)(i). A fiduciary has "authority to control and manage the operation and the administration of the plan," 29 U.S.C. Sec 1102(a)(1).

Firestone Tire & Rubber Co. v Bruch (1989) 489 U.S. 101, 113.

Poole's plan contains the following pertinent provisions (at 85-87):

> The Plan is insured by Metropolitan Life Insurance Company for Life, Accidental Death and Dismemberment, and Short-Term Disability only. The Plan is administered by Metropolitan Life for all other coverages.

* * *

> You have the right to have the plan review and reconsider your claim... If you have any questions about your plan you should contact the plan administrator.
>
> * * *
>
> Employer and Plan Administrator
>
> Orange and Rockland Utilities, Inc.
> One Blue Hill Plaza
> Pearl River, NY
>
> * * *
>
> Agent for Service of Legal Process
>
> For disputes arising under the plan, service of legal process may be made on the plan administrator at the above address. For disputes arising under the insurance contract, service of legal process may be made upon Metropolitan...

Id. at 85-87.

Defendant argues that Orange and Rockland merely "rents out [its] claims processing department [] to review claims and determine the amount payable in accordance with the terms and conditions of the plan." Def. Mem. at 18. In addition, it claims that Orange and Rockland reserved the right to make full and fair reviews of denied claims. In support of its theory defendant cites a

letter dated February 17, 1994 from the Manager of Compensation & Benefits of Orange and Rockland to defendant's Senior Account Executive which authorizes defendant to pay for the type of anesthesiologist bills at issue in this case. That letter states:

> This will serve as an authorization to not exclude "pain management" as a covered expense under our plan. This includes both the Patient Controlled Analgesia (PCA-post surgery) and Epidural Administration (pre/post surgery) types of pain management. Expenses should be covered at reasonable and customary values...
>
> * * *
>
> please have all the claims on the attached listing reprocessed and the expenses for pain management related services covered. All benefits should be paid to our employees, as some have made payments to the providers.

Fuller Decl. Ex. A-4.

The Eleventh Circuit has held that an insurance company which enters into an administrative services agreement with another company to process claims and disburse benefit payments under the terms of an ERISA plan but not to provide benefit insurance for that other company's employees, is not an ERISA fiduciary. See Baker v. Big Star Div. of the Grand Union Co. (11th Cir. 1989) 893 F.2d 288, 290 (granting summary judgment to insurance company sued under ERISA). Similarly, the Sixth

Circuit has ruled that an insurance company was not an ERISA fiduciary where it acted as "merely a claims processor" under a plan which provided that a different company "shall be the Plan Administrator and the named Fiduciary of the Plan as such terms are defined in ERISA and shall control and manage the operation and administration of the Plan," and where it had no right to construe the plan. Baxter v. C.A. Muer Corp. (6th Cir. 1991) 941 F.2d 451, 455-56.[7]

However, as we have held elsewhere, "ERISA does not require that an entity have total discretionary powers before it may be considered a fiduciary." Sixty-Five Sec. Plan v. Blue Cross and Blue Shield (Knapp, D.J.) (S.D.N.Y. 1984) 583 F. Supp. 380, 387. On that occasion we ruled that an insurance company which was not named as an ERISA fiduciary by the plan, but which had the power to make final decisions with regard to approved benefits claims under such plan, was an ERISA fiduciary. Id. Poole argues that defendant, like Blue Cross/Blue Shield in Sixty-Five Security Plan, has final authority as to claims which it approves. Defendant has not disputed that fact.

Defendant has failed to persuade us that no material question of fact exists with regard to its fiduciary status for Poole's plan. We therefore deny its summary judgment motion as to Poole.

---

[7]Cf. Gelardi v. Pertec Computer Corp. (9th Cir. 1985) 761 F.2d 1323, 1325 (An employer loses its status as a plan fiduciary when it appoints a Plan administrator and when it "retain[s] no discretionary control over the disposition of claims").

## CONCLUSION

For reasons stated herein, we grant summary judgment to defendant on all claims asserted by plaintiff Melendez; deny its summary judgment motion as to all remaining plaintiffs; and deny plaintiffs' motion for summary judgment. The parties shall contact chambers to arrange a conference to determine further action.

SO ORDERED

September 15, 1995
New York, New York

/s/ Whitman Knapp
Senior United States District Judge

# APPENDIX B

B-1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---

ANTON SEMMLER, ROSEMARIE LUNNY, MARIO GAITI, DONNA POOLE, and LAURA MELENDEZ, individually and on behalf of all others similarly situated,

Plaintiffs,

- against -

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant.

---

:94Civ. 5549 (SS)

Appearances:

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INSURANCE COMPANY

## OPINION AND ORDER

**SONIA SOTOMAYOR, U.S.D.J.**

Plaintiffs move to reconsider and vacate the ruling of the Hon. Whitman Knapp granting summary judgment dismissing the claim of plaintiff Laura Melendez (the "Melendez judgment"). Plaintiffs further move for leave to amend the Complaint to add an additional plaintiff, Sharon Rocke, and to certify a class pursuant to Fed. R.

Civ. P. 23. For the reasons to be discussed, plaintiffs' motion to reconsider and vacate the Melendez judgment is DENIED; plaintiffs' motion to add plaintiff Sharon Rocke is DENIED, and plaintiffs' motion to certify the class is DENIED.

## BACKGROUND

Plaintiffs are enrollees in various medical benefit plans funded and administered by defendant Metropolitan Life Insurance Company ("Met Life"). They have all undergone one of two forms of post-operative main management: either patient controlled analgesia ("PCA") or epidural narcotic administration ("ENA"). As explained by plaintiffs:

> PCA involves the use of a pump, programmed and monitored under the supervision of anesthesiologists or other trained physicians, which permits a patient to press a button to obtain pain medication intravenously as needed, within the limits set by the physician. [ENA] involves the insertion of a catheter into the epidural space near the spine through which pain medication can be infused continuously and/or intermittently.

(Pl. Class Cert. Mem. at 3). In this action, plaintiffs contest the decision made by defendant's Claims Issues Committee (the "Committee") to deny reimbursement for the expenses incurred in receiving these methods of post-operative pain management. Bringing causes of action based alternatively in the contract language of the plans or under ERISA, plaintiffs insist that they are entitled to reimbursement for

these "medically necessary" procedures performed by physicians and/or anesthesiologists.

Defendant contends that PCA and ENA are not separately reimbursable services. It maintains that post-operative pain management in the form of PCA and ENA is covered by the package surgical fee paid to the physician performing the surgery and to the surgical anesthesiologist. Reimbursing plaintiffs separately for their PCA and ENA treatments would amount to double-billing, in defendant's view, because the physician's package fee covers this treatment and because the physician historically has been responsible for ensuring post-operative pain treatment. Furthermore, defendant claims that PCA is not properly considered a service rendered by a "physician" because it is the patient him or herself who actually administers the pain killers -- perhaps with the assistance of the nurses on duty.

With respect to plaintiff's motion to reconsider and vacate the judgment of the Hon. Whitman Knapp dismissing all claims of plaintiff Laura Melendez, defendant argues that the decision of the Committee to deny reimbursement for PCA was not arbitrary and capricious, but rather was based on substantial evidence after considering the relevant factors. The end product of the Committee's decision was reasonable, defendant urges. Further, defendant claims that "[t]he evidence is clear and uncontradicted that the Committee's decision was <u>not</u> influenced by any alleged conflict or financial interest" that would entitle plaintiff Melendez to de novo review of the Committee's decision. (Def. Vacate Mem. at 21). For these reasons, and because plaintiff Melendez failed to exhaust her administrative remedies as required by the plan and by ERISA, defendant contends that Judge Knapp's

decision dismissing Ms. Melendez's claim should be upheld.

In their motion to amend the complaint to add Sharon Rocke as an additional plaintiff and in their motion for class certification, plaintiffs maintain that all of the requirements for class certification have been met. They contend that the interests of justice will be served by the addition of Rocke as another ERISA plaintiff and that such addition "cannot conceivably prejudice defendant." (Pl. Class Cert. Mem. at 2). Defendant, however, counters that class certification should be denied because: (1) individual issues of law and fact predominate over common issues; (2) the claims of the named plaintiffs are not typical of the claims of the class; (3) the representative parties will not fairly and adequately represent the class; (4) plaintiff's motion for class certification is untimely; (5) class action is not a superior method of resolving plaintiffs' claims. Specifically with respect to the motion to amend the complaint to add plaintiff Rocke, defendant argues that this request should be denied "as untimely and prejudicial, and because Rocke's claim is barred for failure to exhaust administrative remedies." (Def. Class Cert. Mem. at 22).

## DISCUSSION

### I. Motion to Reconsider and Vacate the Dismissal of Melendez's Claim

#### A. Procedural History

In his September, 1995 opinion, Judge Knapp granted defendant's motion for summary judgment against plaintiff Melendez, writing:

> Defendant has provided us with ample evidence of its own historical practice of paying for post-operative pain treatment through its surgical package and that such practice is not uncommon in the medical field. As well, defendant has a [sic] made a strong showing that surgeons are usually qualified to perform all services related to PCA, the type of pain treatment which Melendez received. Thus we are unable to conclude that its decision to reject Melendez' outstanding anesthesiologist's bills was arbitrary and capricious, and we accordingly grant defendant summary judgment against Melendez.

Semmler v. Metropolitan Life Insurance Co., 1995 WL 559390, *11 (S.D.N.Y. 1995). Because, *inter alia*, Judge Knapp did not consider the potential conflict of interest under which Metropolitan Life operated as a self-funded plan, and because of the Second Circuit's intervening ruling in Sullivan v. LTV Aerospace & Defense Co., 82 F.3d 1251 (2d Cir. 1996) which impacts that analysis, this Court permitted a reconsideration of Judge Knapp's ruling.

B. Summary Judgment Standard

The standards for evaluating summary judgment motions are well established. Rule 56(c) provides that summary judgment is appropriate when:

> the pleadings, depositions, answers to interrogatories, and admissions on file,

> together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

Fed. R. Civ. P. 56(c).

The burden is on the moving party to show that no genuine issue of material fact exists. See Gallo v. Prudential Residential Servs., Ltd. Partnership, 22 F.3d 1219, 1223 (2d Cir. 1994) (citation omitted). "material fact is one that would affect the outcome of the suit under the governing law,' and a dispute about a genuine issue of material fact occurs if the evidence is such that 'a reasonable jury could return a verdict for the nonmoving party.'" Iacobelli Constr., Inc. v. County of Monroe, 32 F.3d 19, 23 (2d Cir.1994) (quoting Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986)). Once the movant satisfied its initial burden, the nonmoving party must identify "specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). "If, as to the issue on which summary judgment is sought, there is any evidence in the record from any source from which a reasonable inference could be drawn in favor of the nonmoving party, summary judgment is improper." Cronin v. Aetna Life Ins. Co., 46 F.3d 196, 203 (2d Cir. 1995) (citations omitted). "On cross motions for summary judgment, the standard is the same as that for individual motions for summary judgment and the court must consider each motion independent of the other." Aviall, Inc. v. Ryder System, Inc., 913 F. Supp. 826, 828 (S.D.N.Y. 1996) (citing Heublein, Inc. v United States, 996 F.2d 1455, 1461 (2d Cir. 1993)). "Simply because the parties have cross-moved and therefore have implicitly agreed that no material issues of fact exist, does not mean

that the court must join in that agreement and grant judgment as a matter of law for one side or the other. The court may conclude that material issues of fact do exist and deny both motions." Id.

C. Deferential Review of Committee Decision: Arbitrary or Capricious Standard

In Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), the Supreme Court held that a denial of benefits challenged under ERISA "is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Id. at 115. If the plan vests discretion with a plan administrator or fiduciary, then that fiduciary or administrator's decision is entitled to be upheld unless it is found to be arbitrary and capricious. This is true "regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest." Id. The Supreme Court added, however, that "[o]f course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion." Id. (citing Restatement (Second) of Trusts Sec 187, Comment d (1959)) (internal quotation marks omitted).

Last year, the Second Circuit clarified the analysis to be employed in determining under Firestone whether a conflict of interest renders an administrator or fiduciary's decision subject to de novo, rather than deferential review. The Court held in Sullivan v. LTV

Aerospace & Defense Co., 82 F.3d 1251, 1255 (2d Cir. 1996) that:

> in cases where the plan administrator is shown to have a conflict of interest, the test for determining whether the administrator's interpretation of the plan is arbitrary and capricious is as follows: Two inquiries are pertinent. First, whether the determination made by the administrator is reasonable, in light of possible competing interpretations of the plan; second, whether the evidence shows that the administrator was in fact influenced by such conflict.

Id. If plaintiff succeeds in demonstrating that the plan administrator was "in fact influenced by the conflict of interest," the Second Circuit held, "the deference otherwise accorded the administrator's decision drops away and the court interprets the plan de novo." Id. at 1256.

In the instant case, the plan under review unquestionably granted to defendant discretion to interpret the plan. See Semmler v. Metropolitan Life Insurance Co., 1995 WL 559390, *11 (S.D.N.Y. 1995) (quoting Melendez' plan as providing: "In carrying out their respective responsibilities under the plan, the plan administrator and other plan fiduciaries shall have discretionary authority to interpret the terms of the plan and to determine eligibility for and entitlement to plan benefits in accordance with the terms of the plan.") (See also Def.'s Vacate Mem. at 11 n. 5 (quoting plan); Pl.'s Vacate Mem. at 5 ("Plaintiffs do not dispute that the plan covering plaintiff Melendez...vests defendant with such discretion.")).

The first questions, then, under Sullivan is "whether the determination made by the administrator is reasonable, in light of possible competing interpretations of the plan." Id. at 1255. I find that it was.

1. *The Committee's Rationale*

The Committee's primary[1] reason for its denial of reimbursement for post operative pain management services is set forth in the defendant's Claims Release:

> When processing [PCA and ENA] claims the hospital charges for supplies and medication are to be accepted as covered medical expenses and benefits allowed for these items. However, physicians' fees for pain/narcotic management during the immediate post-operative period should be denied because a benefit allowance for pain control is included in our surgical payment to the operating surgeon. The surgeon's fee has historically included pre and post-operative care and pain control is a necessary part of post-operative care.

---

[1]According to the deposition testimony of Dr. Katz, the Committee was also troubled by the fact that because the PCA pump was largely controlled by the patient him or herself, the device could not be deemed one administered by a physician, as that concept was understood under the health care plan. To the extent this rationale is not expressed in defendant's Claims Release and the defendant's stated rationale in the Release is sufficient to justify its decision, I do not address the Committee's argument on this point.

(Clines Dec. Ex. 3).[2] As further described by Committee member Kelly, the reason for the Committee's decision to deny reimbursement was that the Committee believed "that patient-controlled anesthesia was monitored by the hospital staff and by the surgeon during the surgeon's visits, [that] the surgeon was responsible for the overall care of the patient, and that additional visits by an anesthesiologist were not medically necessary."

(Kelly Dep. at 18). To this end, Dr. Katz personally believed that "post-operative analgesia is part of the global fee that the surgeon accepts, and that post-operative pain control is his obligation," (Katz. Dep. at 44), and therefore should not be reimbursed separately to anesthesiologists. I find these conclusions to be rational and amply supported by the record. I concur with Judge Knapp's findings on this point:

> Defendant has provided us with ample evidence of its own historical practice of paying for post-operative pain treatment through its surgical package and that such practice is not uncommon in the medical field. As well, defendant has made a strong showing that surgeons are usually qualified to perform all services related to PCA....

Semmler, 1995 WL 55930, at *11.

---

[2]In their Motion for Class Certification, plaintiffs concede that the central issue in this litigation is "whether PCA and epidural narcotic administration are in fact separate doctor's services which confer a medical benefit on patients and merit separate compensation." (Pl. Class Cert Mem. at 4) (emphasis in original).

Therefore, because the conclusion of the Committee is rational and supported by the record, under a deferential review, the Committee's conclusion must be upheld. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989); Pagan v. NYNEX Pension Plan, 52 F.3d 438, 442 (2d Cir. 1995) ("Under the arbitrary and capricious standard of review, we may overturn a decision to deny benefits only if it was 'without reason, unsupported by substantial evidence or erroneous as a matter of law.'") (citing cases); id. at 443 ("Where it is necessary for a reviewing court to chose between two competing yet reasonable interpretations of a pension plan, this Court must accept that offered by the administrators.") (citations omitted).

2. *Outside Consultants*

Plaintiff insists that regardless of the result, the process of the Committee's decisionmaking was arbitrary and capricious in that the Committee's purported deference to the conclusion of outside consultants amounted to a dereliction of its ERISA fiduciary duty to make an independent judgment regarding the insurability of post operative pain management services. See Miller v. United Welfare Fund, 72 F.3d 1066, 1072 (2d Cir. 1995) (finding that denial of claim was not supported by substantial evidence and was therefore arbitrary and capricious where Trustees presumably relied solely upon three-sentence report from subcommittee); Mirto v. Amalgamated Retail Insurance, 882 F. Supp. 1386, 1390 (S.D.N.Y. 1995) (holding that Committee's decision was arbitrary and capricious where "[d]espite plaintiff's detailed objections to the findings of the reviewers, the specific reason stated by

the Appeals Committee consist[ed] merely of [the statement that] '[t]he Trustees determined that two independent medical authorities had reviewed the records and concluded that the tests and chiropractic services rendered should not be paid since they were not medically necessary'"); id. (providing that "[t]he burden on the Committee is to examine the record...and, based on that examination, provide its own conclusion and supporting rationale, that is, specific reasons in support of its conclusion.... That burden is not fulfilled by the mere determination that the records had been previously reviewed by medical authorities.").

Plaintiff challenges the Committee's reliance on the advice of outside anesthesiologists --- whose identify was not disclosed to the Committee --- regarding the insurability of PCA and ENA. Plaintiff contends that because the Committee effectively adopted the conclusion of the unidentified outside consultants without scrutinizing their reasoning and qualifications, the Committee failed to exercise the independent judgment required by ERISA. I do not find the plaintiff's assertions supported by the record.

The evidence clearly and indisputably shows that the Committee spent at least forty minutes discussing the issue of reimbursement for post operative pain management techniques. (Katz Dep. at 42). Such an extended discussion is simply not consistent with the blind acceptance of outside consultants' recommendation. It is also inconsistent with the testimony of Ms. Kelly that the "doctors" discussed various aspects of reimbursement for PCA. (Kelly Dep. at 17-18). Furthermore, while plaintiff tries to depict the Committee's approach as totally close-minded, the Committee's very effort to seek the advice of outside consultants who were experts in the field only leads

to the reasonable inference that the Committee took the matter very seriously and fulfilled their obligation under Bierwirth to seek outside expert advice where necessary. See Donovan v. Bierwirth, 680 F.2d 263, 272-73 (2d Cir.), cert. denied, 459 U.S. 1069 (1982); Miller v. United Welfare Fund, 72 F.3d 1066, 1073 (2d Cir. 1995). For these reasons, plaintiff's unsubstantiated argument on this point does not create a material issue in dispute regarding the Committee's alleged arbitrary and capricious decisionmaking.

Plaintiff's best evidence regarding the Committee's purported dereliction of its duty to make an independent judgment comes from the following exchange in Dr. Katz' deposition:

> A. At the next meeting, the report [from Dr. Klipstein regarding the outside consultants' recommendation] was oral and to the fact that this is not an insurable procedure.
>
> Q. Is that all that the report consisted of, or was there further detail?
>
> A. There was not much detail at the time, and the recommendation was to advise Claims in a claims release not to cover patient-administered analgesia[.]
>
> Q. Who was it that made that report to the committee at the subsequent meeting?

A. Dr. Clipstein. [sic]

Q. Did she state any reason for her recommendation?

A. Well, she indicated she had consulted with outside anesthesiologists and they did not feel this was a medical service covered under insurance policies.

Q. Did you ask her which outside anesthesiologists she consulted with?

A. No, I didn't.

* * *

Q. Did you ask any questions about the reasons that were given to her for why it was not an insurable procedure?

A. No, I didn't.

Q. Did anybody?

A. I don't think anybody challenged Dr. Clipstein's [sic] suggestions.

Q. Were you satisfied yourself that her recommendation was a proper basis

for the Claims Issue Committee to make its own recommendation?

A. Yes, I was satisfied with her report.

* * *

Q. Would you tell us, please, as best you can recall, exactly what Dr. Clipstein [sic] said?

A. To the best of my recollection,, she said the person or persons which she consulted did not recommend additional payments for patient-controlled analgesia.

Q. And did she indicate in any way that the person or persons she had consulted were anesthesiologists?

A. Yes, she did.

* * *

Q. And did she say anything else?

A. Not that I can remember.

Q. Did she give any reasoning for the conclusion?

A. No, she gave us no reason.

Q. And was there any discussion by anybody else at that meeting on this question?

A. No, there wasn't.

Q. And was a vote taken?

A. Yes. It was unanimous.

Q. Do you recall how much time was spent on that particular issue?

* * *

A. At that meeting? We must have spent anywhere from forty to fifty minutes on this issue.

Q. Sitting there in silence?

A. No, no, there was discussion, and there was some questions, and the answers were somewhat curt and short, but it did not just slide by, you know.

* * *

Q. And as those questions were being raised during this forty-minute discussion, what response did Dr. Clipstein [sic] give to them?

A. What it came down to is this; if it's controlled by the patient, it is obviously not a medical service, and if it is not a medical service, then we shouldn't cover it.

Q. Who said that?

A. Dr. Clipstein [sic].

Q. And did she given [sic] any other explanation?

A. No.

(Katz Dep. at 39-42, 44). This passage is troubling to the extent that, in places, it suggests that the Committee's consideration of the outside consultants' report was at best curt and superficial. However, it is difficult to discern to what extent this characterization of the Committee's decisionmaking is a result of Dr. Katz's attempt in his deposition to recall the minute details of a conversation which took place over six years before. Internally inconsistent at points, the deposition testimony at worst reveals that Dr. Katz' memory is hazy on the precise contours of the conversation but is clear on the most important issues -- that the Committee considered at length the relevant issues and made a decision after independent deliberation. In light of this fact and given Ms. Kelly's testimony regarding the Committee's decisionmaking (Kelly Dep. at 17-18), I find that plaintiff has not raised a sufficient issue of material fact in dispute upon which to proceed to trial.

As a matter of law, I find that even if Dr. Katz' testimony were taken at its worst, the record is still clear that the outside consultants' recommendation was but one factor the Committee considered in arriving at its own conclusion regarding the reimbursement for post operative pain management services. Even as Dr. Katz characterizes the Committee's decision, I find that such a process does not rise to the level of dereliction of duty that has been found to violate ERISA. Cf. Miller v. United Welfare Fund, 72 F.3d 1066, 1072 (2d Cir. 1995) (holding that Trustees' denial of reimbursement was not supported by substantial evidence where Committee appeared to rely solely on fund administrator's three sentence report that merely listed the amount in controversy, the names of the documents submitted by plaintiff and the service for which plaintiff was presenting a claim; A[r]eliance on such limited information to deny the claim was arbitrary and capricious," especially where fund administrator failed to include or explain all of the items in the administrative record, each of which Aeither buttressed [plaintiff's] position or was neutral."); Mirto v. Amalgamated Retail Insurance, 882 F. Supp. 1386, 1390-91 (S.D.N.Y. 1995) (providing that claim administrator's burden to arrive at independent judgment regarding claim "is not fulfilled by the mere determination that the records had been previously reviewed [and claim recommended denied] by medical authorities.").

3. *Extra Contractual Condition*

In her final argument, plaintiff contends that defendant, in contravention of clear ERISA case law, see e.g., Shelden v. Barre Belt Granite Employer Union Pension Fund, 25 F.3d 74, 80 (2d Cir. 1994); Crean v. New York

City District Council of Carpenters Pension Fund, 1996 WL 389248, * 5 (S.D.N.Y. 1996), imposed an extra contractual condition on its decision to grant or deny reimbursement for PCA. Plaintiff argues that Dr. Katz' answer to the following questions from plaintiff's counsel reveals that such an extra contractual condition was imposed:

> Q. And with respect to the policy that was adopted at Met Life, do you recall whether separate compensation to an anesthesiologist is something that could be considered if there were complications in the medical sense with respect to the condition of the patient?>
>
> A. Yes.
>
> Q. You do recall that, and that was something that could be considered under Met Life's policy, right?
>
> A. Right.

(Katz Dep. at 88; quoted at Pl. Vacate Mem. at 13). I disagree.

The above exchange, rather than demonstrating that Met Life imposed extra contractual conditions on its decisionmaking regarding customary PCA, shows that Met Life made a practice of considering extenuating circumstances that might merit a departure from their normal practice of denying reimbursement for such services. Rather than supporting plaintiff's contention, this

passage instead affirms defendant's argument that such a practice is common and is "in accordance with the generally accepted practice that treatment of complications resulting from a compensated procedure is a separate incident meriting consideration for separate payment." (Def. Vacate Mem. at 20). Because plaintiff has not shown that "there were complications in the medical sense with respect to [her] condition," I cannot see how the Committee's purported practice of making exceptions in exceptional cases bears any relevance to this discussion. Hence, I cannot find that any extra contractual condition was imposed in the instant case.

In sum, and for all the reasons indicated, I find that the Committee's decision to deny separate reimbursement for PCA was rational and should be upheld under the highly deferential review standard articulated in Firestone. The facts themselves are not in dispute; the only question is what judgment to take from them. I cannot conclude that plaintiff "raise[d] any factual issue sufficient to challenge the reasonableness of the decision." Mirto, 882 F. Supp. at 1389. As a matter of law, I conclude that the decision of the Committee was rational. See Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 251-52 (1986) (court must determine "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law.").

D. De Novo Review of Committee Decision: Conflict of Interest in Fact

Under Sullivan, the second level of inquiry for the Court to undertake is whether the plan administrator

was in fact influenced by a conflict of interest in his or her decision to deny benefits. See Sullivan, 82 F.3d at 1256. Here, plaintiff has failed to demonstrate that any such conflict of interest in fact influenced the Committee's conclusions. Plaintiff alleges that because there is no "reasonable" explanation for the Committee's decision, it must have been the result of a financial conflict of interest. (See Pl. Vacate Mem. at 6 ("[T]he only explanation for the otherwise inexplicable claims policy arrived at by plaintiffs is Metropolitan Life's underlying financial interest in denying reimbursement.")). The Court does not find such an inference reasonable.

First, and perhaps most importantly, because I have previously found that the decision of the Committee was reasonable, I do not credit plaintiff's argument that the only rational explanation for the decision of the Committee was that the Committee was influenced by a financial conflict of interest.

Second, plaintiff points to no evidence that would indicate that the Committee's decision was based on financial motivations. Rather, in at least one instance it appears that the Committee's decision to deny reimbursement was made despite the potential for *negative* financial consequences. (See Katz Dep. at 45, 49-50 (discussing "concern[]" of some members of the Committee that the decision to deny reimbursement would dissatisfy policyholders).

Moreover, there is direct evidence in the testimony of both Committee members that cost played no role in the Committee's consideration. In his deposition, Dr. Katz testified as follows:

> Q. And did it ever come to your attention during the course of the meeting what the cost of PCA claims was to the company?
>
> A. No, cost was not a consideration.

(Katz Dep. at 45-46). In addition, Dr. Katz testified that he had no idea what the cost of the services at issue were. (Katz Dept. at 46-48). When asked a similar question in her deposition, Ms. Kelly testified:

> Q. Would the financial impact on Met Life with respect to policies where MetLife acted as the insurer ever be discussed by the [Committee]?
>
> A. That was not a concern of the [Committee]. Obviously, you know, if we work for Met Life we are concerned about Met Life and Met Life being a successful company, but the mission of this committee was to make decisions based on appropriate reimbursement for the contracts that we had in place, and we made very attempt to be as fair as possible under the terms of the contracts. The decisions were not driven by what the impact would be to Met Life.

(Kelly Dep. at 147; see also id. at 149 ("Q. Was there any discussion by anyone at the [Committee] meetings of the

financial impact of whether to pay a separate reimbursement for PCA on MetLife? A. Not that I remember.")). Ms. Kelly also testified that the Committee never "receive[d] information as to the potential financial impact on Met Life of a claims policy decision[.]" (Id.) In fact she said that in order to understand the financial impact on MetLife of the decisions made by the Committee, one would have to have the skills of an actuary, and no such actuary was typically in attendance at Committee meetings. (Id. at 148). This testimony amply supports the defendant's contention that no conflict of interest in fact influenced the Committee's decision to deny reimbursement for PCA.[3] And, in light of the fact that plaintiff has produced no evidence to the contrary, summary judgment in favor of the defendant is appropriate.

In sum, I conclude that plaintiff has not demonstrated the influence in fact of a financial conflict of interest, as required by Sullivan. De novo review of the Committee's decision is therefore inappropriate. Plaintiff has not put forward a genuine issue of material fact upon which to proceed to trial. For this reason, defendant's summary judgment motion with respect to plaintiff Melendez is granted.[4] See Anderson v. Liberty Lobby, Inc.,

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[3]In addition, defendants note that the Committee's decision was applicable "not just to ERISA plans were MetLife was the insurer, but also to ERISA plans for which MetLife did not insure but merely administered claims." Def.'s Vacate Mem. at 10-11).

[4]Because the Court has granted the defendant's summary judgment motion on the merits, there is no need for the Court to address the question whether plaintiff Melendez appropriately exhausted her administrative remedies, as required under ERISA. See e.g., Kennedy v. Empire Blue Cross and Blue Shield, 989 F.2d 588, 594 (2d Cir. 1993) ("This Court has recognized the firmly established federal policy favoring

477 U.S. 242, 251-52 (1986) (court must determine "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law.").

## II. Motion to Amend Complaint to Add ERISA Plaintiff Sharon Rocke

Plaintiffs seek to amend the complaint to add an additional ERISA plaintiff, Sharon Rocke. Upon the Court's request, both plaintiffs' and defendant's counsel submitted evidence that the plan fiduciary under Rocke's health care plan was afforded "full power and discretion to resolve all issues concerning eligibility, status, entitlement to benefits, and any other interpretations under each of the benefit plans described in this book." (MetLIfe Policy, Attachment to Clines Letter to Court, 3/19/97). In light of my above finding that the Committee's decision to deny reimbursement for post operative pain management must be upheld under the arbitrary and capricious standard of review afforded plans that grant administrators discretion, I deny plaintiffs' motion to amend the complaint to add a plaintiff against whom I would immediately have to grant summary judgment. As the Second Circuit stated in Acito v. Imcera Group, Inc., "[a]lthough the decision whether to allow the plaintiffs to amend their complaint is left to the sound discretion of the district court, there must be good reason to deny the motion One good reason to deny leave to amend is when such leave would be futile." 47 f.3d 47, 54 (2d Cir.

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exhaustion of administrative remedies in ERISA cases.'") (quoting Alfarone v. Bernie Wolff Construction, 788 F.2d 76, 79 (2d Cir.) cert. denied 479 U.S. 915 (1986).

1995) (citations omitted).

## III. Motion for Class Certification

Given that my above conclusion regarding the Melendez judgment and the motion to amend has left plaintiffs with no remaining representative for the potential class or subclass of ERISA litigants, I must deny plaintiffs' request for class certification because there is a failure of typicality and fair and adequate representation. See Fed. R. Civ. P. 23(a). See also Kenavan v. Empire Blue Cross Blue Shield, 1996 WL 14446, *4 (S.D.N.Y. 1996), aff'd sub nom., Schmookler v. Empire Blue Cross Blue Shield, 1997 WL 64204 (S.D.N.Y. 1997). Therefore, I dismiss the motion for class certification of these litigants without prejudice unless within sixty days of the date of this Opinion and Order an ERISA plaintiff under a plan with no fiduciary discretion is granted leave to intervene. If a representative of this class does intervene, the Court will then have to consider whether the above-described class or subclass of ERISA plaintiffs is sufficiently numerous to satisfy Fed. R. Civ. P. 23(a)(1) and whether the individual question of exhaustion of administrative remedies predominates over the common question of defendant's liability. See Fed. R. Civ. P. 23(b)(3); Kenavan, at *4.

With respect to the named plaintiffs whose plans are not governed by ERISA, I find that if no ERISA representative meeting the above requirements intervenes in this action within sixty days of the date of the Opinion and Order, Aall bases for federal jurisdiction will have been eliminated form this case." Kenavan, at *5. If there is no such intervention and thereby no remaining basis for federal

jurisdiction, I will adopt the reasoning of my colleague, Judge Kimba Wood, in Kenavan, and remand the state law claims of the non-ERISA plaintiffs to state court, where they may seek class certification. See id. (citing cases); Gelb v Board of Elections, 950 f. Supp. 82, 86-87 (S.D.N.Y. 1996) (citing cases providing that where federal bases of jurisdiction are dismissed before trial, recommended practice is to remand remaining state law claims to state court).

## CONCLUSION

For the reasons discussed above, plaintiff's motion to reconsider and vacate the judgment of Judge Whitman Knapp regarding plaintiff Melendez is DENIED. Plaintiffs' motion to amend the complaint is likewise DENIED. With respect to plaintiffs' motion for class certification, I DENY the motion without prejudice, unless within sixty days from the date of this Opinion and Order an ERISA plaintiff whose plan affords the administrator no discretion is granted leave to intervene. If no such intervention is granted, the remaining non-ERISA plaintiffs' claims will be remanded to state court for lack of a remaining basis for federal jurisdiction.

As noted in my memorandum endorsement of October 3, 1996, I am prepared to grant a Rule 54(b) certification of my decision. Counsel should consider whether it would be more prudent, however, to defer the certification until such time as the class certification motion is finally resolved. In any event, counsel for both parties are instructed to appear before the Court for a status conference on **Friday, April 18, 1997 at 3:00 p.m.**

**SO ORDERED**

Dated: New York, New York
March 21, 1997

/s/ Sonia Sotomayor
United States District Judge

# APPENDIX C

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

**SUMMARY ORDER**

**THIS SUMMARY ORDER WILL NOT BE PUBLISHED IN THE FEDERAL REPORTER AND MAY NOT BE CITED AS PRECEDENTIAL AUTHORITY TO THIS OR ANY OTHER COURT, BUT MAY BE CALLED TO THE ATTENTION OF THIS OR ANY OTHER COURT IN A SUBSEQUENT STAGE OF THIS CASE, IN A RELATED CASE, OR IN ANY CASE FOR PURPOSES OF COLLATERAL ESTOPPEL OR RES JUDICATA.**

At a stated term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse, Foley Square, in the City of New York , on the 7th day of January, one thousand nine hundred and ninety-eight.

Present: HONORABLE RALPH K. WINTER,

Chief Judge,

HONORABLE JON O. NEWMAN,

HONORABLE J. CLIFFORD WALLACE,*

Circuit Judges.

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ANTON SEMMLER, ROSEMARIE LUNNY, MARIO GAITI, individually and on behalf of all others similarly

situated, DONNA POOLE
Plaintiffs,

LAURA MELENDEZ, individually and on behalf of all others similarly situated,

Plaintiff-Appellant,

- v. - No. 97-7528

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant-Appellee.

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Appearing for Appellant: Peter James Clines, Landy & Seymour, New York, New York.

---

*The Honorable J. Clifford Wallace, of the United States Court of Appeals for the Ninth Circuit, sitting by designation.

Appearing for Appellee: Robert J. Fuller, Coppell, Texas.

Appeal from the United States District Court for the Southern District of New York (Sotomayor, Judge).

This cause came on to be heard on the transcript of record from the United States District Court for the southern District of New York and was argued.

ON CONSIDERATION WHEREOF, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the judgment of the District Court is hereby affirmed.

Laura Melendez appeals from Judge Sotomayor's denial of her motion to reconsider and vacate Judge Knapp's ruling granting appellee summary judgment and dismissing Melendez's ERISA claim. Melendez first argues that Metropolitan Life Insurance Company ("Met Life"), as the administrator of a health insurance plan covered by ERISA, 29 U.S.C. Section 1000 et seq. (1994), violated its fiduciary obligation to her in denying her request for reimbursement for post-operative pain management services provided by her anesthesiologist. In addition, Melendez urges us to alter the standard of review used in evaluating an administrator's interpretation of a benefit plan in cases where the administrator is shown to have a conflict of interest. We will address the second of these issues first.

Where, as in the instant case, a benefit plan grants discretionary authority to construe the terms of the plan to an administrator shown to have a conflict of interest, we subject the administrator's interpretation to two inquiries: "First, whether the determination made by the administrator is reasonable, in light of possible competing interpretations of the plan; second, whether the evidence shows that the administrator was in fact influenced by such conflict." Sullivan v. LTV Aerospace & Defense Co., 82 F.3d 1251, 1255-56 (2d Cir. 1996). If a plaintiff succeeds in showing that the administrator was actually influenced by the conflict of interest, "the deference otherwise accorded the administrator's decision drops away and the court interprets the plan de novo." Id. at 1256; see also Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989) ("[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion.") (internal quotations and citation

omitted).

We decline to alter the current standard. Melendez asks us to adopt the reasoning of Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1563 (11th Cir. 1990), which shifted the burden to the fiduciary to prove that its interpretation of the plan was not colored by its conflict of interest. However, we have specifically declined to follow Brown three times in as many years. See Whitney v. Empire Blue Cross & Blue Shield, 106 F.3d 475 (2d Cir. 1997); Sullivan, 82 F.3d 1251; Pagan v. NYNEX Pension Plan, 52 F.3d 438 (2d Cir. 1995). Even in DeFelice v. American Int'l Life Assur. Co., 112 F.3d 61 (2d Cir. 1997), on which Melendez's argument on this point solely relies, we acknowledged that "Whitney indicates that Sullivan binds our court to the holding of Pagan . . ., which rejected Brown." DeFelice, 112 F.3d at 66 (internal citation omitted).

With regard to Met Life's denial of Melendez's claim for reimbursement, we affirm for substantially the reasons set forth in Judge Sotomayor's opinion. Semmler v. Metropolitan Life Ins. Co., 172 F.R.D. 86 (S.D.N.Y. 1997).

We therefore affirm.

FOR THE COURT:
GEORGE LANGE, III, Clerk
/s/ Lucille Carr 1/7/98
By: Date

Supreme Court, U.S.
FILED
MAY 27 1998
OFFICE OF THE CLERK

No. 97-1630

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1997

LAURA MELENDEZ,

*Petitioner,*

—v.—

METROPOLITAN LIFE INSURANCE CO.,

*Respondent.*

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

## RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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32 pp

## PARTIES TO THE PROCEEDING

The caption correctly lists the parties to the proceeding. Respondent Metropolitan Life Insurance Company ("MetLife"), a mutual life insurance company, has no parent or subsidiaries that have issued shares to the public. The only affiliates of which MetLife has actual ownership (for its own account) which have issued shares to the public are: (1) Chart House Enterprises, Inc., in which MetLife owns 12.65% of issued, voting shares; (2) Lone Star Industries, Inc., in which MetLife owns 13.47% of issued, voting shares; (3) New England Investment Companies, L.P., in which MetLife owns 48.64% of issued, voting shares; and (4) Dan River, Inc., in which MetLife owns 26% of issued, voting shares.

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## STATEMENT OF THE CASE

The arguments in both the District Court and the Second Circuit focused on whether it was reasonable for respondent Metropolitan Life Insurance Company ("MetLife"), an ERISA claims administrator exercising its discretion, to decide that it should pay only one doctor, rather than two doctors, to write a single prescription and make rounds to monitor petitioner's pain medication following surgery. As detailed below, petitioner's surgeon billed and was paid a "package" fee which included compensation for these services. MetLife's rejection of duplicative bills from petitioner's anesthesiologist for the same services gave rise to the parties' dispute. MetLife's determination has been reviewed and found reasonable three times in this case—by two different District Judges and by the Second Circuit.

Petitioner now seeks review of an issue which was not raised in the District Court, which was raised only in cursory fashion before the Second Circuit, and which could not have altered the outcome in either court. That issue is who bears the burden of proving that a conflict of interest did (or did not) influence the benefit determination. The District Court found that uncontradicted evidence *affirmatively* established that MetLife's benefit determination was *not* influenced by a conflict of interest. That finding supports the judgment for MetLife regardless of whether MetLife or petitioner has the burden of proof on that issue. Review by this Court would be pointless because the sole issue presented here cannot change the outcome of this case.

### Procedural History

The reasonableness of MetLife's rejection of duplicative benefits for post-operative pain services was first presented to Senior District Judge Whitman Knapp. No issue with respect to conflict of interest was raised at that time. In his September 15, 1995 Opinion, Judge Knapp found that MetLife's determination was not arbitrary and capricious, and granted summary judgment dismissing petitioner's claim. *Semmler v. Metropolitan*

*Life Ins. Co.*, 1995 WL 559390 (S.D.N.Y.) (reprinted in Petitioner's Appendix (hereafter "App.") at A-1).

After this case was reassigned to District Judge Sonia Sotomayor, petitioner requested and was given leave under Fed. R. Civ. P. 60(b) to seek reconsideration of Judge Knapp's judgment in light of the intervening decision of the Second Circuit in *Sullivan v LTV Aerospace & Defense Co.*, 82 F.2d 1251 (2d Cir. 1996), which set out analytical steps for determining the impact of a conflict of interest on the standard of review under ERISA. Petitioner raised the conflict of interest issue for the first time in her Rule 60(b) motion. Ironically, *Sullivan*—which petitioner now asks this Court to overrule—is the very precedent which petitioner used to obtain leave to file her Rule 60(b) motion. Petitioner relied heavily on *Sullivan* in arguing her motion to the District Court, and in no wayquestioned the holding in *Sullivan* that the claimant bears the burden of proving that the benefit determination was influenced by a conflict of interest. Accordingly, the District Court did what both parties urged, i.e., applied the *Sullivan* analysis to the facts established by the evidence.

In her March 21, 1997 Opinion, Judge Sotomayor found that MetLife's benefit determination was "rational and amply supported by the record," concurring with Judge Knapp's finding that the determination was not arbitrary and capricious as a matter of law. *Semmler v. Metropolitan Life Ins. Co.*, 172 F.R.D. 86 (S.D.N.Y. 1997) (reprinted at App. B-1). With respect to the new conflict of interest issue, Judge Sotomayor found that MetLife was entitled to judgment because direct, uncontroverted evidence established the fact that MetLife's determination was not influenced by a conflict. 172 F.R.D. at 94-95 (App. B-22 to B-24).[1]

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[1] The claims of three other plaintiffs under non-ERISA plans were remanded to state court. As petitioner concedes, the state court subsequently ruled that the arbitrary and capricious standard of review applies regardless of MetLife's purported conflict of interest. Therefore, petitioner's assertion that ERISA claimants are disadvantaged by the standard of review is not only irrelevant but also untrue in this case. The

In her appeal to the Second Circuit, petitioner again focused her argument on the contention that MetLife's benefit determination was arbitrary and capricious. The Second Circuit rejected that contention for the same reasons articulated by both Judge Knapp and Judge Sotomayor. *Semmler v. Metropolitan Life Ins. Co.*, 1998 WL 4069 (2d Cir.) (reprinted at App. C-1). In the last two pages of her 48-page brief to the Second Circuit, petitioner raised for the first time the issue of who bears the burden of proving that a conflict did (or did not) influence the benefit determination. Based solely on a dicta comment in a footnote to *DeFelice v. American Ins. Co.*, 112 F.3d 59, 66, n.3 (2d Cir. 1997), petitioner invited the Second Circuit to overrule this aspect of *Sullivan* (the same case on which petitioner had based her argument to the District Court).

The Second Circuit declined petitioner's belated invitation to overrule *Sullivan*'s allocation of the burden of proof. (App. C-4). The Second Circuit's discussion of that issue in its unpublished opinion, however, is dicta. The Second Circuit affirmed the judgment against petitioner on the merits, based on the undisputed facts found by Judge Sotomayor, which include the finding that MetLife affirmatively established by direct, uncontroverted evidence that its decision was not influenced by a conflict of interest. Because there was no genuine issue of fact as to the effect of the alleged conflict, the allocation of the burden of proof on that issue was inconsequential.

**Factual Background**

Petitioner was insured under the Securities Industry Indemnity Automation Corporation Plan, an ERISA plan for which MetLife both insured benefits and provided claims administration. That plan:

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state court applied the same standard of review, but viewed the facts differently in finding a fact issue, a matter inappropriate for review on certiorari and irrelevant to the sole issue presented here. The burden of proof issue which petitioner raises here was not even mentioned in the state court's opinion, nor in any of the parties' briefing in state court.

(1) prohibited duplication of benefits,

(2) limited coverage to "Reasonable and Customary" charges (defined as the lowest of the actual charge or the usual charge for the same or similar services) for services determined by MetLife to be medically necessary,

(3) granted MetLife discretion to determine entitlement to benefits, and

(4) provided for administrative review of those determinations.

Petitioner underwent surgery. Her surgeon and her anesthesiologist submitted bills for MetLife's consideration. Petitioner's post-operative pain medication was injected via patient controlled analgesia ("PCA").[2] MetLife paid for the drugs, PCA pump, intravenous tubing and other equipment involved, in addition to paying the surgeon a "package" fee which included compensation for prescribing the drugs and for making daily rounds to check on petitioner's condition.[3]

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[2] The Petition also refers to the pain control method of epidural narcotic administration ("ENA"). Petitioner, however, did not receive any ENA services and has made no claim for ENA benefits. No issue with respect to ENA was presented to the District Court in connection with the judgment from which petitioner appealed to the Second Circuit. Bills for insertion of epidural catheters involve issues not presented by duplicative PCA bills. Accordingly, petitioner's discussion of ENA is irrelevant here.

[3] The concept of a surgical "package" fee is a medical industry standard, as set out in the *Physician's Current Procedural Terminology* ("CPT"), published by the American Medical Association to provide a uniform language for reporting physician services under health insurance plans. The CPT defines the surgical "package" as the operation per se and the normal post-operative care, including post-operative pain control. The CPT also provides for a modifier code, which must be used if the surgeon bills for only part but not all of the services normally included in the surgical package. Petitioner's surgeon billed and was paid under the CPT code for the entire surgical package, without the modifier code, which by definition included the post-operative pain control services at issue.

MetLife also paid the "package" fee billed by petitioner's anesthesiologist for the surgical anesthesia.

Petitioner's anesthesiologist submitted two additional bills: (1) $210 for prescribing the PCA drugs, and (2) $140 for PCA "follow-up" on the day after the surgery. In accordance with the provisions of petitioner's plan, MetLife declined to pay these two duplicative bills. The plan directly prohibited duplication of benefits. In addition, because benefits for the same or similar services had already been paid to the surgeon, allowance of additional benefits would have exceeded the "Reasonable and Customary" charges for the services provided, and thus would have exceeded the plan's express limitations on coverage. Petitioner did not request administrative review.[4]

Petitioner's claim was processed in accordance with a uniform claims policy determined by MetLife's Claims Issues Committee. MetLife formed the Claims Issues Committee to provide consistent and reasoned policies for handling claims under thousands of health plans. Many of these plans were self-funded and retained MetLife to administer claims for a fee. The committee's membership included four medical doctors, two of whom had relevant experience in surgery and anesthesiology.

The Petition mischaracterizes the committee's deliberations regarding PCA. The only evidence of those deliberations is the deposition testimony of former committee members Sarah Kelly and Robert Katz. Dr. Katz had 34 years experience

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[4] Because she found that MetLife was entitled to summary judgment on the merits, Judge Sotomayor did not reach the issue of whether petitioner's claim was barred for failure to exhaust her administrative remedies. In declining to directly reach that issue, however, Judge Sotomayor did note that controlling precedent requires exhaustion of administrative remedies under ERISA. 172 F.R.D. at 95, n.4 (App. B-24) (citing *Kennedy v. Blue Cross and Blue Shield*, 989 F.2d 588, 594 (2d Cir. 1993)). Petitioner's admitted failure to exhaust her administrative remedies is an independent reason why review could not change the outcome in this case.

as a practicing surgeon and was a member of the American Medical Association's CPT Advisory Committee. As a surgeon, Dr. Katz had routinely prescribed post-operative pain medication and monitored the effectiveness of that medication during his daily hospital rounds. Dr. Katz had observed the use of PCA by his surgeon colleagues in hospitals where he practiced. At the time of his deposition, Dr. Katz had been retired from MetLife for three years and had no interest in the outcome of this case.

Prior to petitioner's surgery, the Claims Issues Committee met twice to examine the questions raised by separate billings from anesthesiologists for post-operative PCA. In its deliberations, the committee considered:

(1) the fact that surgical package fees include compensation for prescribing and monitoring post-operative pain medication,

(2) the fact that surgeons make daily hospital rounds to monitor their patients,

(3) the redundancy inherent in having two physicians round the same patient, and

(4) the generally accepted standard of practice under which the surgeon accepts and bills for the responsibility of post-operative care, including pain control.

The evidence before the District Court also included testimony from other distinguished surgeons, surgical nurses and a hospital administrator, who confirmed the standards of medical practice which guided the deliberations of the Claims Issues Committee. These experts corroborated:

(1) the fact that surgeons can and typically do write prescriptions for post-operative PCA, which is then administered by the nursing staff and monitored by the nurses and by the surgeons during their daily rounds;

(2) the fact that the surgical package fee paid by MetLife includes compensation for these services; and

(3) the fact that separate charges for post-operative PCA services are atypical and inappropriate.

This evidence was summarized in Judge Knapp's Opinion. 1995 WL 559390, *6-9 (App. A-14 to A-23).

The committee unanimously concluded that duplicate benefits should not be paid to both the surgeon and the anesthesiologist for post-operative PCA. The committee's findings were summarized in a "Claims Release", which was distributed to MetLife claims processors and subsequently used in processing petitioner's claim.

Committee members Katz and Kelly were rigorously cross-examined by petitioner's counsel as to whether financial interests of MetLife had any effect on the committee's deliberations. Their testimony was consistent, unequivocal and uncontroverted that the committee *never* considered, discussed or received any information regarding the potential financial impact on MetLife of *any* of its myriad of claims policy decisions, including the PCA decision. As Kelly explained, the financial impact on MetLife of claims policy decisions is so complex that only an actuary could understand it, and no actuary was present at the committee meetings. This testimony was summarized in Judge Sotomayor's Opinion. 172 F.R.D. at 94-95 (App. B-22 to B-24).

Petitioner makes the unsupported assertion that denying duplicative benefits for PCA saved MetLife "millions of dollars." That assertion ignores the effects of retroactively rated premiums, as well as the fact that the committee's claims policies applied equally to self-funded plans for which MetLife administered but did not insure claims. In actuality, the net financial impact on MetLife of denying a particular type of claim could be positive, negative or negligible, depending on such factors as (1) the premium structures of plans insured by MetLife, (2) the fee structures of plans administered but not insured by MetLife, (3) the relative numbers of enrollees and volumes of that type of claim under each type of plan, (4) the average dollar amount of such claims, and (5) the increased

time and administrative expense normally attendant to denying as opposed to paying claims.[5]

The evidence is undisputed that the committee's members had neither the information nor the actuarial skills necessary to determine the net financial impact of claims policies as applied to the full range of plans administered by MetLife, and that the committee never discussed or considered such matters. Thus the summary judgment evidence proved not only that the committee's deliberations were not influenced by any conflict of interest, but also that the committee did not know and lacked the ability to determine whether and to what extent a conflict even existed.

## REASONS FOR DENYING THE WRIT

### I. The Rule Proposed By Petitioner Would Not Change the Outcome In This Case.

Petitioner contends that the Circuits have split in applying this Court's observation that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there has been an abuse of discretion." *Firestone Tire & Rubber v. Bruch*, 489 U.S. 101, 115 (1989) (citing the Restatement (Second) of Trusts, Sec. 187, cmt. d (1959), which lists conflict of interest as one of six factors which "may be relevant" in determining whether a trustee has abused discretion).

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[5] To illustrate, under a self-funded plan which paid MetLife fees based on the dollar amount or volume of claims paid, denial of a claim would have the negative financial impact of reducing MetLife's fees and increasing its administrative costs. Under a retroactive premium plan insured by MetLife, the financial impact of denying that claim could be positive, negative or negligible, depending on the exact premium structure, the amount of the claim and the variance in administrative costs. Under a non-retroactive premium plan, denying that claim could have a positive financial impact if the amount of the claim exceeded the increased administrative costs of denying it.

It is true that none of the other Circuits has accepted that aspect of the Eleventh Circuit's approach which places the burden on the administrator to prove that a conflict did not influence its decision. However, that aspect of the Circuits' analysis is not relevant in this case because, as the District Court found, MetLife did prove by direct, uncontroverted evidence that the alleged conflict did not influence its decision. Accordingly, discretionary review under Rule 10 of the Supreme Court Rules is not appropriate in this case, and the Petition should be denied.

### A. The Circuits Use a Fact-Specific Approach to Determine the Effect of a Conflict of Interest.

Although the precise formulation of the analysis varies, the Circuits which petitioner contends are split have each taken a fact-specific approach, examining the evidence to determine whether the alleged conflict of interest was "relevant" in the sense that it had any discernable impact on the benefit determination. For each Circuit, the heart of the inquiry is whether the evidence shows that the conflict affected the reasonableness of the decision or of the decisionmaking process.

This fact-specific approach is evident even in the sole case upon which petitioner relies, *Brown v. Blue Cross & Blue Shield*, 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1440 (1991). In *Brown*, the Eleventh Circuit held that the application of the arbitrary and capricious standard "is shaped by the circumstances" and depends "on the dynamics of the decisionmaking process." 898 F.2d at 1563-64. The administrator in *Brown* had originally denied payments for two periods of hospitalization, and then changed its position for one of those periods on the basis of new evidence. In continuing to deny benefits for the other period, the administrator's interpretation was inconsistent with analogous provisions of the plan. The Eleventh Circuit viewed these inconsistencies as evidence that the administrator's decision was tainted by self-interest. 898 F.2d at 1569.

Petitioner asserts that the Ninth Circuit's approach set out in *Lang v. Long Term Disability Plan*, 125 F.3d 794 (9th Cir. 1997), is "in direct tension with *Brown*." Petition at 17. In *Lang*, however, the Ninth Circuit repeatedly cited *Brown* with approval, 125 F.3d at 797-98, and expressly looked to *Brown* for "specific guidance" as to what facts will constitute "sufficient, probative, material evidence" that a benefits determination was influenced by a conflict of interest. 125 F.3d at 798. Like the Eleventh Circuit in *Brown*, the Ninth Circuit in *Lang* found such evidence from inconsistencies in the decisionmaking process.[6] Based on that evidence, the Ninth Circuit held that the benefit determination was not entitled to deference, reversed the judgment for the plan, and ordered payment of benefits. 125 F.3d at 799.

Similarly, the Fourth Circuit in *Bedrick v. Travelers Ins. Co.*, 93 F.3d 149 (4th Cir. 1996), looked to the facts to determine the impact of the conflict of interest. From the depositions of the insurer's employees, the court found evidence that the conflict had tainted the benefit determination. The depositions revealed (1) that the insurer's initial medical necessity determination (that walking by age five would not be "significant progress" for a child with cerebral palsy) was baseless, and (2) that the reviewers on administrative appeal did not make a judgment about the appropriateness of the care, and viewed their role as being a "supporter" of the insurer's legal department. 93 F.3d at 153-54. In this factual context, the Fourth Circuit held that deference must be "lessened to the degree necessary to neutralize any untoward influence resulting from the conflict." 93 F.3d at 152.

The Tenth Circuit in *Chambers v. Family Health Plan*, 100 F.3d 818 (10th Cir. 1996), affirmed a judgment for the insurer

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[6] The administrator in *Lang* had initially denied disability benefits because the disability was not "caused or contributed to" by a physical ailment. When confronted with clear evidence to the contrary, the administrator still denied the benefits on the basis that the physical ailment was not the sole cause, stating that it looked to "symptoms, not cause" in interpreting the plan. 125 F.3d at 799.

despite the existence of a "significant conflict of interest." 100 F.3d at 827. Again, the Court based its decision on extensive review of the evidence, which led to the conclusion that the decision to classify the medical procedure at issue as experimental "was reasonable in light of the administrative record," and thus was not impacted by the conflict. *Id.*[7] Although the Court in *Chambers* did note some divergence in approaches among the Circuits, it concluded that the Tenth Circuit's approach to analyzing the impact of a conflict was consistent with the approaches taken by the Second, Fourth, and Ninth Circuits. 100 F.3d at 825-26.

Under the "sliding scale" of deference suggested by the Fourth and Tenth Circuit cases, the focus of the courts' review is still on the reasonableness of the decision and the process by which it was reached. *See, e.g., Semtner v. Group Health Services of Oklahoma, Inc.*, 129 F.3d 1390, 1393 (10th Cir. 1997) ("The touchstone of our inquiry is whether defendant's interpretation of its plan is reasonable."); *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997) (despite conflict of interest, decision will be upheld if it is "the result of a deliberate, principled reasoning process and if it is supported by substantial evidence").

The analysis of the Second Circuit has the same basic focus. As in all Circuits, the mere existence of a conflict of interest is not determinative. Rather, the court must examine the facts established by the evidence to determine whether "the conflict affected the reasonableness of the [administrator's] decision." *Sullivan*, 82 F.3d at 1259 (quoting *Pagan v. NYNEX Pension*

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[7] In *Chambers*, the court pointed to the fact that the Health Care Financing Administration ("HCFA") had not yet decided whether to cover the procedure or not, as evidence that the insurer's decision was reasonable. 100 F.3d at 826. The evidence in the present case is much stronger. As noted in Judge Knapp's opinion, HCFA came to the same conclusion that MetLife reached, rejecting separate billings for PCA on the basis that "[p]ayment for physician services related to Patient Controlled Analgesia (PCA) is included in the global fee paid to the surgeon." 1995 WL 559390, *9 (App. A-23) (quoting 3 *Medicare Report* 906, 913 (BNA, July 24, 1992)).

*Plan*, 52 F.3d 438, 443 (2d Cir. 1995)). The two-step analysis set out in *Sullivan*, and applied by each court below in the present case, reflects the core inquiries recognized by all Circuits: (1) "whether the determination made by the administrator is reasonable," and (2) "whether the evidence shows that the administrator was in fact influenced by such conflict." *Sullivan*, 82 F.3d at 1255.

Despite variations in phrasing, careful examination of the above cases reveals a consistent pattern of fact-specific inquiry as to the effect of the alleged conflict. The analytical anomaly of the Eleventh Circuit—in placing the burden of proof on the administrator—is inconsequential in the present case because here that burden was clearly met. Therefore, review is not warranted and the Petition should be denied.

### B. Undisputed Facts Support the Judgment in this Case Regardless of How the Burden of Proof is Allocated.

Petitioner assumes—without ever directly addressing the question—that shifting the burden to MetLife to prove that the alleged conflict did not affect its determination would change the outcome of this case. That assumption ignores the District Court's finding that MetLife *did* prove that the alleged conflict did not have—and in fact could not have had—any impact on its decision. That finding was based on *uncontroverted* evidence. Therefore, regardless of how the burden of proof is allocated, no genuine issue of material fact was presented.

District Judge Sotomayor began her analysis by acknowledging the traditional burdens under a summary judgment motion: (1) the initial burden on the moving party (here MetLife) to prove that no genuine issue of material fact exists; and (2) if the initial burden is satisfied, the burden of the nonmoving party to identify "specific facts showing that there is a genuine issue for trial." 172 F.R.D. at 89 (App. at B-7) (quoting Fed. R. Civ. P. 56(e)). With these burdens in mind, Judge Sotomayor made the following fact findings.

First, Judge Sotomayor found that MetLife's determination not to pay duplicative benefits for PCA was "rational and amply supported by the record." 172 F.R.D. at 90-91 (App. at B-11). Secondly, Judge Sotomayor examined the evidence regarding the decisionmaking process and found that MetLife's Claims Issues Committee "considered at length the relevant issues and made a decision after independent deliberation." 172 F.R.D. at 93 (App. at B-18). Because petitioner failed to raise "any factual issue sufficient to challenge the reasonableness of the decision," Judge Sotomayor concluded that the committee's decision was rational as a matter of law, citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251-52 (1986), for the principle that summary judgment should be granted where the evidence "is so one-sided that one party must prevail as a matter of law." 172 F.R.D. at 94 (App. at B-21).

Judge Sotomayor then turned to petitioner's argument regarding conflict of interest. Like the plaintiffs in *Brown*, *Lang* and *Bedrick*, petitioner argued that the alleged irrationality of the decision was evidence that the decision was tainted by a conflict. Judge Sotomayor rejected that argument—not because petitioner faced an impossible evidentiary burden, as the Petition now asserts—but rather because the facts in this case did not support it. 172 F.R.D. at 94 (App. B-22).

The judgments for the plaintiffs in *Lang* and in *Bedrick* conclusively refute petitioner's assertion that it is impossible for a plaintiff to satisfy the burden of producing evidence that a benefit decision was influenced by a conflict. Evidence which satisfies that burden is typically circumstantial and may be inferred from inconsistencies in the decisionmaking process or from defects in the reasoning of the decisionmaker, as in *Lang* and in *Brown*, or may be developed through cross-examination of the decisionmaker in depositions, as in *Bedrick*. However, when the undisputed facts affirmatively show that the conflict did not affect the decision, as in the present case, the plaintiff does face an impossible task. In that situation, it makes no practical difference whether the impossible task is that of initially producing nonexistent evidence, or that of rebutting

the defendant's direct evidence without having any contrary evidence.

As a summary judgment movant, MetLife assumed and met the burden of proving all facts necessary to support the judgment. Regardless of how the burden of proof on the conflict issue is allocated, a properly supported summary judgment motion cannot be defeated without producing affirmative evidence. *Anderson*, 477 U.S. at 257. This settled principle controls the outcome in this case notwithstanding petitioner's protests that the administrator typically has exclusive possession of the evidence of whether a conflict affected its decision. *Anderson*, 477 U.S. at 257 (to defeat properly supported motion for summary judgment, plaintiff must present affirmative evidence "even where the evidence is likely to be within the possession of the defendant"). *See also Guillory v. Domtar Industries, Inc.*, 95 F.3d 1320, 1326 (5th Cir. 1996) (even where the movant's intent is at issue, there is an actual controversy sufficient to defeat summary judgment only if both parties have submitted evidence of contradictory facts); *Meister v. Georgia Pacific Corp.*, 43 F.3d 1154, 1159 (7th Cir. 1995) (same); *Clements v. Nassau County*, 835 F.2d 1000, 1005 (2d Cir. 1987) (same).

Because the District Court found that MetLife *did* prove that its decision was not affected by the alleged conflict, whether MetLife had the burden to do so is an academic question. Where there is an actual controversy as to the effect of an alleged conflict, i.e., where the parties submit evidence of contradictory facts or where neither party submits evidence relevant to that issue, the question of who has the burden of proving the effect of the conflict may be pertinent. But in the present case, where the evidence was clear and uncontradicted, the allocation of the burden is inconsequential. Shifting an evidentiary burden to a party who has already met that burden would not change the outcome; MetLife would still be entitled to summary judgment under the facts found by the District Court.

Even if this Court were inclined to address the anomaly in the Eleventh Circuit's treatment of this issue, it should not select this case to do so. Review could not change the outcome in this case and would produce only dicta. Thus, because there is no compelling reason for granting discretionary review, the Petition should be denied.

## II. The Decision in this Case is Consistent with Public Policy Underlying ERISA.

Petitioner asserts that the decision below "stands ERISA on its head" by giving deference to an allegedly conflicted claims administrator, thereby transforming ERISA protection into a liability for beneficiaries. The facts of this case expose the fallacies in petitioner's rhetoric.

The remedial purposes of ERISA do not include paying all benefit claims, regardless of their merits, or encouraging doctors to double bill for their services. Such recklessness would send the already high costs of medical insurance into the ozone, which is clearly not in the interests of ERISA beneficiaries. The bottom line in this case is that petitioner wants MetLife to pay both her surgeon and her anesthesiologist to provide a single service, i.e., to prescribe and monitor petitioner's pain medicine. Such double billing for routine services is obviously in the financial interests of the anesthesiologists who financed this lawsuit,[8] but it is not in the interests of ERISA beneficiaries as a whole, and it is prohibited by petitioner's ERISA plan.

Petitioner also ignores the fact that ERISA was not intended to provide absolute neutrality in claims administration, but rather contemplated administration by employees of interested parties. *See Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995) (ERISA "specifically provides that employers

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[8] As revealed in connection with petitioner's request for class certification, this lawsuit is one of several putative class actions instigated and financed by a non-profit organization of anesthesiologists. These lawsuits challenge various claim reimbursement policies designed to curtail unnecessary or duplicative billings by anesthesiologists.

may appoint their own officers to administer ERISA plans even if the company is a 'party in interest.' 29 U.S.C. § 1108(c)(3). Plainly and not surprisingly, ERISA contemplates less neutrality than is required in a judicial forum."). In enacting ERISA, Congress was surely aware that insurance companies frequently function as both insurer and claims administrator, and yet ERISA in no way discourages or forbids this common practice. Moreover, petitioner's ERISA plan obviously contemplated that MetLife would both insure benefits and decide claims, and yet expressly granted MetLife discretion to determine the merits of the claims. *See Childs v. National Bank of Austin*, 658 F.2d 487, 490 (7th Cir. 1981) (applying abuse of discretion standard to actions of conflicted trustee when "the conflict is contemplated, created, and expressly sanctioned by the trust instrument").

What ERISA does require is consistent, reasoned, and reasonable claims policies. That is precisely what MetLife provided in this case. The claims policy at issue was deliberated and decided by a committee of experts, and then uniformly applied without regard to whether the policy operated to the financial benefit or detriment of MetLife. The committee was insulated from any financial concerns, lacked the information and skills required to ascertain the complex financial impact of its claims decisions, and never discussed such matters. Yet petitioner asks this Court to strip the committee's determination of all deference, based solely on the happenstance that the committee members' employer insured benefits under the particular plan to which the committee's uniform policy was applied in this case.

It is petitioner, not the Second Circuit, who seeks to stand ERISA—as well as settled summary judgment law—on its head. Petitioner would have the courts remake every ERISA claims decision judicially, whenever the claimant makes an unsupported assertion that the decision was influenced by a conflict of interest, and even when the uncontroverted evidence directly refutes that contention. That approach would impede rather than advance ERISA's goal of providing both

fair and efficient administration of benefit claims, and would needlessly impose on the district courts' crowded trial dockets. Thus, because there is no compelling reason under Rule 10 for discretionary review by this Court, the Petition should be denied.

## CONCLUSION

The Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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Supreme Court, U.S.
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**ORIGINAL**

No. 97-1630

In The
# Supreme Court of the United States
October Term, 1997

LAURA MELENDEZ,

*Petitioner,*

vs.

METROPOLITAN LIFE INSURANCE CO.,

*Respondent.*

*On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit*

## RESPONDENT'S OBJECTION TO MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF IN SUPPORT OF PETITION FOR CERTIORARI

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## CORPORATE STATEMENT

Respondent Metropolitan Life Insurance Company ("MetLife"), a mutual life insurance company, has no parent or subsidiaries that have issued shares to the public. The only affiliates of which MetLife has actual ownership (for its own account) which have issued shares to the public are: (1) Chart House Enterprises, Inc., in which MetLife owns 12.65% of issued, voting shares; (2) Lone Star Industries, Inc., in which MetLife owns 13.47% of issued, voting shares; (3) New England Investment Companies, L.P., in which MetLife owns 48.64% of issued, voting shares; and (4) Dan River, Inc., in which MetLife owns 26% of issued, voting shares.

## OBJECTION TO MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF IN SUPPORT OF PETITION FOR CERTIORARI

Pursuant to Supreme Court Rule 37.5, respondent MetLife objects to the motion for leave to file *amicus curiae* brief in support of petition for certiorari, filed by Citizen Action of New York and Public Policy and Education Fund, on behalf of themselves and organizations from six other states ("Consumer Organizations"), for the following reasons:

1. Consumer Organizations' motion is not favored under Supreme Court Rule 37.1 because the proposed brief does not contain any relevant matter not already brought to the Court's attention by the petition for writ of certiorari. The brief attempts to make three points. As demonstrated below, none of these points is relevant in this case.

a. The primary focus of Consumer Organizations' brief is public concern about managed health care. That topic is irrelevant in this case. The claim at issue here was not made under a managed care plan. No issue with respect to managed care has ever been raised in this case.

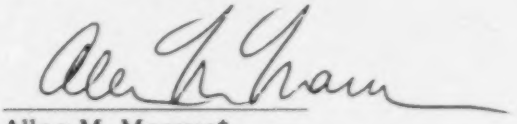
b. Consumer Organizations' brief repeats petitioner's argument that the arbitrary and capricious standard of review unfairly disadvantages ERISA beneficiaries, as compared to claimants under non-ERISA plans. That argument is merely repetitive, and is also irrelevant and incorrect in this case. Petitioner concedes that the same standard of review, which the District Court applied to the ERISA claim below, was also applied by the state court to the non-ERISA claims after remand of those claims. Petition at p. 4.

c. Consumer Organizations conclude their brief by proposing "independent review by qualified health care professionals who do not have any financial interest in the outcome of the decision." Proposed Brief at p. 9. That proposal is irrelevant here. Petitioner did not request administrative review of the benefit denial at issue in this case. Petitioner does not ask this Court to modify the administrative appeal provisions of her plan. Neither petitioner nor Consumer Organizations contend that those provisions fail to meet the requirements of ERISA. To implement Consumer Organizations' proposal, ERISA must be amended to require independent administrative review. That proposal should be directed to Congress, not this Court.

2. Because Consumer Organizations' motion was filed before the Court's consideration of the petition for writ of certiorari, it is not favored under Supreme Court Rule 37.2(b).

WHEREFORE, respondent Metropolitan Life Insurance Co. asks that Consumer Organizations' motion for leave to file *amicus curiae* brief be denied.

Respectfully submitted,



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MetLife®

May 12, 1998

**By Federal Express**

Francis J. Lorson
Chief Deputy Clerk
Supreme Court of the United States
One First Street, N.E.
Washington, DC 20543

Re: Melendez v. Metropolitan Life Insurance Co.
United States Supreme Court No. 97-1630

Dear Mr. Lorson:

I am enclosing for filing an original and 10 copies of Respondent's Objection to Motion for Leave to File *Amicus Curiae* Brief in Support of Petition for Certiorari as well as an original Certificate of Service.

Also enclosed is an additional copy of the Objection and Certificate of Service which I would appreciate your date stamping and returning to me in the enclosed, self-addressed stamped envelope.

Thank you for your consideration and please feel free to call me if you have any questions.

Sincerely,

Allan M. Marcus

encl.

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